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Ethical Principles for Hospital Design

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Dedication

I would like to dedicate this thesis to my wife, thanking her for her support, patience and encouragement during my study.

Ethical Principles for Hospital Design

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Abstract:

The subject of this thesis is 'Ethical Principles for Hospital Design'. The mission of this research is to identify the ethical principles for hospital design in the form of a structured framework for ethical discourse about the medical environment. I think this thesis addresses a gap in the current literature, in which, there is not really an already existing structured framework for ethical discourse about the hospital environment. The ethical principles for hospital design can guide designers to identify their ethical duties toward users of the hospital environment (e.g. patients, staff, and visitors). For this sake, I will be engaging with literature that is critical of using the concept of dignity in biomedical contexts, as well as, Nussbaum's capability understanding of dignity. In the introductory chapter, I will explain my reasons for working on this subject and briefly introduce the content of each chapter. In the second chapter, I will discuss the concept of human dignity from the viewpoint of Kant. I will then consider the standpoint of Nussbaum in relation to the meaning and the theory of human dignity. In the third chapter, I will link the idea of human dignity to the notion of human entitlements in the hospital environment. In this regard, I will explain and develop the implications of human dignity in Nussbaum's thought and, accordingly, I will suggest a list of the entitlements of people in hospitals. Such a list of entitlements is the first part of the ethical method in hospital design which I call the *dignity approach.* The second part is addressed in the fourth chapter, in which I will suggest and elaborate upon three ethical principles; namely, *design for vulnerability*, *design for healing*, and *design for reverence*. These will form my proposed basic ethical principles of hospital design grounded in respect for human dignity and entitlements. Suggesting the dignity approach, I will, also, be critiquing and seeking to supplement in a certain way the influential Evidence-Based Design approach in hospital design. The last chapter will supply a conclusion of the arguments of this thesis and indicate some directions for future research.

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Chapter 1

1. Introduction

1.1. My Professional Experience

The reason that I decided to work on this research goes back to my personal experience when I was working in an Iranian medical university as a civil engineer[1]. My colleagues and I were responsible for supervising the construction projects of the university (e.g. building hospitals, clinics, etc.), as well as the technical maintenance of its pre-existing hospitals. Whilst working there, I observed many non-medical needs of patients and their families which could not be met. This neglect was not because the medical teams were neglecting their patients' rights, but because the hospital environment did not allow them to respond appropriately to the legitimate demands of their patients.

For instance, I observed an older patient wearing a surgical gown which did not properly cover him. That person had to be carried to the operating theatre on a trolley through a public corridor. I felt the man was deeply embarrassed about his situation when other people could see him in the corridor. The medical team could do nothing for that patient because there was no other way to carry the patient to the operating theatre. Hence, I thought perhaps hospital designers could protect that patient from public view by, for example, providing a private corridor for these occasions. Likewise, my colleague told me that he observed a trauma patient who was screaming when his trolley moved over a ramp in a hospital. Going over the bumps caused his fractured body to be shaken forcefully and this exacerbated his suffering. This problem could be solved simply by making the surface of that ramp smooth and without bumps, for example. Similarly, there were many instances of inappropriate design which caused patients difficulties by increasing their pain, stress, anxiety, depression, and so on.

The people who use the hospital environment are not only patients, of course. The environmental condition of a hospital also affects the relatives of patients. One of the common problems patients' families had to face in the hospitals I saw was being separated from their

[1] In Iran, public hospitals are managed by public medical universities. In other words, public hospitals are University hospitals.

hospitalised family-member. The environment of these hospitals usually did not have any provision to accommodate relatives who wished to visit with the patient, and hence, medical staff could not let them in. Therefore, they were kept separated outside the wards, and this caused an increase in stress for these relatives.

What I learnt from these cases of unsuitably designed hospitals was the fact that considering the ethical requirements of patients in hospitals should be incorporated into the process of design. When a patient comes to hospital in a vulnerable condition she cannot protect herself as she could do in her normal life. In this situation, the staff of the hospital cannot provide for all the ethical requirements of patients if the environment of the hospital is not facilitated for such a service. Thus, if the ethical needs of patients in hospital matter, as they surely do, then those who can make it possible should contribute to providing for patients' moral demands, too. Thus, in this way, we can see that the designers of hospitals have ethical responsibilities to the people who use those environments.

This means that the ethical needs of patients should be considered in hospital planning. Disappointingly, when I considered the process of planning and constructing healthcare environments, I noticed that designers mostly focused on what was necessary for the treatment process: hospitals are usually seen as merely a place of treatment, and the non-medical requirements of people were not sufficiently weighted. I do not mean that the designers rejected any demand if it was related to ethical requirements, or that such demands were insignificant for them. On the contrary, if they noticed the importance of any ethical requirement in their projects then they attempted to address it with the means of design and the environment. The problem I saw was that there was no systematic structure either highlighting such ethical requirements or leading the designers to a way in which they could discover such requirements. They were not even told that considering ethical requirements was their ethical responsibility.

The question that puzzled me was the following: how we can help designers to identify these sorts of non–medical issues in their planning process? An ethical approach was needed to underscore this duty for designers, an approach which could address all of the relevant moral conditions comprehensively. I decided to examine the idea of 'human dignity' in my work in order to see if this concept could guide designers to find the ethical elements involved in their planning of hospitals. To do this, I asked one of my colleagues, who was an architect, to visit the cardiac department of one of the hospitals of the University I was working for (as a case study) and try to list the elements of design she thought tended to work against the dignity of patients. My colleague asked me to explain more to understand what I was looking for. I gave some examples of undignified situations that I had seen in hospitals and explained how the

design of the hospital might protect patients from such unpleasant conditions. I asked her to visit the department and examine it carefully and attempt to find such subtleties in the environment of that department.

Unfortunately, I left my job before I could review her findings. However, what was interesting and essential for me was the point that my colleague, as an architect and not as a philosopher, transparently understood what I asked for. She even started to give me some further examples of the situations where the hospital environment can work against the dignity of people. She told me that her father was ill in that period of time, and since her father was important to her and she respected him, she was concerned about the unethical conditions her father may experience in hospital. Although I could not discuss her findings, the mere understanding of my ideas about the ethical environment by a hospital designer indicated a vital point for me: an appropriate ethical approach can draw the attention of hospital designers to focus on and identify their ethical responsibilities towards the people who use the hospital environment created by them. The goal of this thesis is to define such an ethical approach for hospital design.

1.2. What Am I Looking for?

I found the concept of dignity instrumental in giving an idea to designers about the ethical requirements of people in hospitals. However, designers may perceive different issues if they were asked to consider human dignity in their planning: as I mentioned above, I needed to give some examples to my colleague so as to clarify what I meant by respecting dignity in the hospital environment. As I will show in the next chapter[2], I found the same problem in the literature and relevant documents. The concept of dignity plays a central role in such sources when they try to depict their non-clinical expectations of the hospital environment. However, it seems they need to accompany the notion of dignity with some other ethical conceptions (e.g. privacy, confidentiality, etc.) in order to clarify what aspect of dignity were intended.

This means that if we want to render an ethical method of hospital design in which notions such as patients' dignity and rights are objects of concern, we need to make those notions clear for designers. In other words, ethical expectations such as patients' dignity and rights should be interpreted in the hospital context with designers' language. In fact, we should explain what designers should do in their planning in order to respect the dignity of people. This concern should be unified with a clear understanding about people's requirements in hospitals: it is

[2] See section 2.1.

necessary to determine what the main ethical requirements of people are, and how these requirements can be joined with what the designers can do. This does not mean that the environment-related entitlements of people in hospitals have not yet been considered. However, they are not discussed comprehensively or in a systematic manner. They are scattered and addressed arbitrarily.

An ethical approach to design should also be able to determine the entitlements of people in a systematic way; a way in which designers can ensure that they are considering, at the very least, the main entitlements in their planning. Thus, what should be expected from an ethical method for hospital design is that it incorporate all of these concerns: it should provide designers with a sensible understanding of the notions of patients' dignity and patients' rights; it should determine what designers have to do in order to respect the dignity and rights of patients in healthcare environments, and it should provide a systematic way for designers to ensure that they are aware of, at least, the main ethical requirements of people in hospitals.

Unfortunately, there are no substantial available arguments or suggestions addressing the environmental design-related ethical requirements of people in hospital. Many different ways might be suggested for such an ethical method of design. My strategy, however, is to establish such an ethical method of design on the basis of a philosophical theory which can provide all the means necessary to deal with the aforementioned concerns. Again, a different theory might be offered for this purpose, but I found the Capabilities Approach of Martha Nussbaum (Nussbaum 2006, 2008) satisfactorily responsive to these concerns. Having this strategy, I will attempt to develop the intellectual foundations of such an ethical approach to hospital design in this thesis (I will not have enough space to address all of the relevant issues concerning the ethical approach of design in this thesis. Therefore, I will focus mostly on the theoretical aspects of such an approach).

I will elaborate upon the theory of the Capabilities Approach by concentrating on the notions of human dignity and entitlements, so as to have an appropriate basis for an ethical method of hospital design. Hence, this research will focus on theoretical aspects and has a philosophical spirit. However, it should be noted that the users of the suggested ethical approach will be designers. Therefore, I will try to render my ethical approach to design in a way that is sufficiently sensible and instrumental for designers, as they are not usually trained for ethical arguments. The ethical approach of hospital design – which I call the *dignity approach* – is supposed to incorporate the ethical demands into the process of design.

1.3. Breakdown of Chapters

In the next chapter, I will briefly investigate some medical documents and literature in order to show that the main ethical expectations of the hospital environment are described by the two notions of patients' rights and patients' dignity. Human dignity is also the basis of Nussbaum's Capabilities Approach. Therefore, I focus on her account of this notion and then consider how this concept is linked to the conception of human entitlements. However, since Nussbaum's thoughts on different aspects of human dignity and entitlements are scattered in her writings, I will consider her thoughts on the basis of a discussion of the Kantian account of dignity (Kant 2012, And 1996). This is because Kant's account of dignity is one of the most influential accounts of dignity, which deeply affected the arguments of the modern era. Moreover, this can help me to explain Nussbaum's notion of dignity by showing which aspects of Kant's account are improved upon or changed in her theory.

I will divide the arguments concerning human dignity into three main areas – namely, the meaning, the implications, and the theory of human dignity. I will explain that the *meaning* of dignity for Kant is 'value' along with certain characteristics such as being unconditional, incomparable, inherent, and inalienable. As the main *implications* of Kant's dignity, I will discuss 'respect', 'duty/responsibilities', 'rights/entitlements', and 'human equality'. The most controversial aspect of Kantian dignity is his *theory* about dignity, according to which only those who have the capacity of rational agency are dignity-bearers. After explaining the features of human dignity in Kant's view, I will address some objections to the use of human dignity as a central concept in biomedical ethics and in so doing consider the relevant arguments of scholars including Ruth Macklin and Doris Schroeder.

Subsequently, I will start to elaborate upon Nussbaum's account of human dignity by considering the ways in which it differs from Kant's. I will explain how, for Nussbaum, the notion of dignity has two meanings: the first is similar to the Kantian notion of the inalienable worth of human beings. The second meaning, however, does not have the characteristic of being inalienable, and concerns the notion of 'a decent life'. I will label this meaning 'dignity as decency'. The final part of chapter two concerns Nussbaum's theory of human dignity. In contrast to Kantian dignity, I will show that, for Nussbaum, human beings are valuable not only for their rationality, but also for a range of capabilities arising from their sociability and embodiment all of which are valuable. In general, in the second chapter I will address the theoretical aspects of Nussbaum's notion of dignity.

Chapter three focuses more on the implications or practical aspects of dignity, trying to show how Nussbaum's notion of dignity can be connected to the notion of human entitlements - and how such entitlements can be brought into the context of the hospital environment. I will develop Nussbaum's arguments in the light of my discussion of the implications of Kantian

dignity. One of the main features of Nussbaum's notion of dignity is her suggested list of basic capabilities. This list is instrumental in identifying the entitlements of people in hospital. After explaining the implications of Nussbaum's account of dignity, I will begin to define the ethical method of hospital design which I will call the *dignity approach.* This approach has two parts. The first part is to determine the ethical entitlements of people in hospitals. In this regard, I will suggest a compatible list of capabilities identifying the entitlements of people in hospitals by modifying Nussbaum's list. This specification is inspired by ideas from both NHS documents and empirical findings in which the effect of the hospital environment on people is investigated.

The second part of the dignity approach is developed in chapter four. In this chapter, I will attempt to find the appropriate ethical principles which can comprehensively show the pathways by which people might be deprived of their basic entitlements. In this regard, the two main ethical missions and associated ethical principles of hospital designers will be introduced and explained: to stop worsening and to start enhancing the capabilities of human beings. The ethical principle of *design for vulnerability* represents the former mission (i.e. stop worsening). This principle suggests protecting people from a worsening situation when in hospital, i.e. to protect them from potential harms. Two other ethical principles, *design for healing* and *design for reverence,* will be offered which invite designers to consider their second mission (start enhancing the capabilities of people in hospitals).

The principle of design for healing focuses on the harms people may suffer that are related to the reasons they go to hospitals. The principle of design for reverence, however, addresses the environmental harms which are imposed on them by being in the hospital environment. I will also endeavour to explain why I think the dignity approach can fill the gap in the literature on the ethics of hospital design, by analysing the Evidence-Based Design as a recent method of hospital design. The last chapter offers a conclusion to the thesis where I will review the foregoing arguments. Finally, I will suggest some areas for further studies in order to improve the findings of this research.

Chapter 2

2. The Human Dignity in Capabilities Approach

2.1. Dignity and Entitlements in the Hospital Environment

Nowadays, there are extensive studies on the rights of patients and ethical conditions in hospitals. Patients' rights profoundly affect medical documents and guidelines. These rights reflect prevailing concerns about the moral status of patients as human beings. Human dignity plays a substantial role in describing such moral status. The World Health Organization (WHO) conceives patients' rights as based on human dignity and equality:

> Formalized in 1948, the Universal Declaration of Human Rights recognizes "the inherent dignity" and the "equal and unalienable rights of all members of the human family". And it is on the basis of this concept of the person, and the fundamental dignity and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians and by the state, took shape in large part thanks to this understanding of the basic rights of the person (WHO 2015).

Patients' rights, however, are not limited to clinical aspects of healthcare service such as access to emergency healthcare service or the right to autonomy and to make decisions. Patients' rights also include the ethical needs of patients such as respect for their integrity, privacy, confidentiality, and so on. For example, the NHS in Scotland has listed the following rights for patients: "Access: [patients'] rights when using health services; Confidentiality: the right for […] personal health information to be kept secure and confidential; Communication and participation: the right to be informed, and involved in decisions, about health care and services; Respect: the right to be treated with dignity and respect; Safety: the right to safe and effective care; Comments and complaints: the right to have a say about your care and have any concerns dealt with, and what you can do if you feel your rights have not been respected" (NHS Scotland, 2012).

As can be seen, some patients' rights are not a part of the process of care, such as rights to respect, to make comments, and to complain. Therefore, when we talk about the rights of patients, this encompasses different types of rights which include the ethical rights of patients. If patients have rights based on their ethical needs, then states and healthcare providers have

corresponding responsibilities to address such ethical rights. This means that anybody who has a role in the process of care (directly or indirectly) has moral duties towards patients.

Moreover, if human dignity is the foundation of patients' rights, then consequently the ethical needs of hospital patients should be based on patients' dignity (Lin, Watson et al. 2013)[3]. General population surveys among 41 countries show that, after communication, dignity in care is believed to be the second most important aspect of non–clinical quality of care (Valentine, Darby et al. 2008). However, dignity and the ethical needs of patients in hospitals can be addressed in various ways and by different means, and these include the physical environment of hospitals.

Undoubtedly, to respond to patients' rights it is essential to facilitate the ways patients can reach their entitlements. The hospital environment, in this regard, can be considered one of the vital tools which can assist (or discourage) medical staff in their handling of their ethical responsibilities towards patients. Thus, the physical environment of hospitals is one of the major mediums which influences the dignity of patients, which indicates that at least some patients' rights should be addressed through the physical environment of hospitals (Henderson, Van Eps et al. 2009). It implies that besides all of the technical difficulties in hospital design, it is also expected that hospitals provide a humane environment (Smith 1984: 1599).

References to dignity and rights in hospital design are not uncommon, although they are also not always clear. There is ample research that talks about the importance of respecting dignity through the environment of the hospital. However, the meanings attached to the concept of dignity vary. For instance, the leadership of the Colorado Mental Health Institute — Pueblo (CMHIP) in the State of Colorado expected the environment of their new hospital to be able to communicate "to patients a sense of dignity, autonomy, and privacy". However, in their explanations of this expectation, it becomes apparent that they mostly applied the notion of dignity in terms of respecting patients' privacy (Dvoskin, Radomski et al. 2002).

Another example is a literature review in which the researchers strove to find out the benefits of single–bed rooms in hospitals. They defined some outcome measures to assess the function of single–bed rooms which included the privacy and dignity of patients, noise levels and quality of sleep, patient satisfaction with care, hospital infection rates, patient safety, complications and length of stay (Glind, Roode et al. 2007: 155). Here dignity is attached to privacy as a single criterion while other parameters such as patient satisfaction are mentioned

[3] In this and the next chapter I will elaborate the concept of dignity and this claim.

in different measures. The use of these other measures can be seen to suggest that respecting patients' dignity is a separate criterion that does not include their satisfaction, safety and the like.

To evaluate the level of respect afforded to patients' dignity in maternity wards in Malawi, as another example, researchers asked both mothers and midwives in three healthcare centres about their practice of privacy, confidentiality, communication and cleanness in the ward (Chigwenembe 2011). In this case, therefore, those four parameters are presented as components of dignity. More interestingly, some researchers claim that the size and design of the infrastructure of hospitals affects the dignity of patients (Chigwenembe 2011: 9). Dignity in hospitals is even described as something which is about 'small things'. These small things can include having working, well–maintained toilet door–locks (Logan 2012)[4].

For some patients, dignity is a concept which is used to convey a sense of having the ability to meet their personal routine without the need of help from others. Some patients do not want to ask for help so that they can maintain their dignity (Tadd, Hillman et al. 2012: 34). In this regard, they may expect that the design of hospitals could offer environments that better support their disability and reduce the need to ask for help. These are a few examples which illustrate that although the concepts of dignity and rights are frequently used in the context of the hospital environment and its design, the meanings which they are intended to convey can differ.

The role of hospital environments in terms of patients' dignity and rights is also reflected in some medical guidelines. For example, NHS Wales has published the *Achieving Excellence Design Evaluation Toolkit (AEDET),* in order to evaluate the design of healthcare buildings by a series of "clear and non–technical statements". This toolkit addresses three main areas: impact, quality and functionality of hospital design, each of which has several criteria to assess the condition of the hospital. In section C (Staff and patient environment) of the section concerning impact, the NHS proposes this criterion:

> The building respects the dignity of patients and allows for appropriate levels of privacy and dignity (NHS Wales, 2013).

The NHS, in this statement, not only expects buildings to respect the dignity of patients directly, but also assumes that structures can provide conditions for appropriate levels of dignity in hospitals. This means that physical environments can respect the dignity of patients which itself is the basis of their ethical rights. As another example, the Department of Health

[4] See also Eileen Shepherd (2012).

in the UK has published the *Essence of Care*, which echoes the views of people and carers on health and social care needs and preferences (Department of Health 2010b: 6). It has several benchmarks involving Benchmarks for Respect and Dignity. Looking at the indicators of the dignity benchmarks, it becomes evident that some of them are directly related to the physical environment of hospitals, such as creating private and quiet areas for patients (Department of Health 2010a: 18).

Providing private areas is not only necessary for the personal interests of patients, but it is also essential for medical outcomes. In emergency departments, for instance, since spaces are typically separated only by curtains, patients may have less privacy. Consequently, they might hesitate to report all of their medical problems to practitioners which could result in misdiagnosis and medical errors (Lin, Lee et al. 2013: 1, Ulrich, Zimring et al. 2004: 14). The fact that some elements of dignity benchmarks for hospitals should be provided by hospital designers signifies that even if medical teams want to serve their patients in an ethical way, they may face difficulties if the hospital design does not facilitate an appropriate physical environment.

The above examples illustrate that the general theme of ethical requirements expecting dignity and rights to be respected in hospital design is not something unfamiliar. Therefore, talking about dignity in hospital design as a strategy is not equivalent to talking about a completely new issue in this field. However, the concept of dignity itself, and the ways patients' rights should be understood in the context of the hospital environment, are not sufficiently transparent as to enable designers to understand their obligations in the ethical planning of hospitals. As was seen, perceptions of dignity vary. Sometimes the concept of dignity has been equated with some other patients' right such as privacy, confidentiality and so on. Therefore, we need to elaborate the definition of dignity, its varying aspects, and its relation to patients' expectations from the hospital environment.

Despite the ambiguous definition and characteristics of dignity, the above examples have illustrated that the environment of hospitals *can* profoundly affect the conditions of patient dignity. Since, on the one hand, dignity is the basis of patients' rights, and on the other hand, the environment of hospitals can contribute to respecting the dignity of people in hospitals, then hospital designers have an ethical duty to consider the dignity of people in hospital. In other words, designers not only have to provide a suitable environment which facilitates the process of treatment in hospitals, but they also have an ethical duty to offer an environment

that has the ability to address the ethical needs of patients[5].

The question is now: how should the issue of patients' dignity and rights in the context of hospital environments be understood by designers? It should be noted that designers are not usually trained to appraise ethical arguments. Therefore, it is hard for them to figure out what it is that such notions entail in their discipline. These notions need to be brought into their field of study and work in a more sensible and practical way. They should be interpreted with clearer principles so that designers can be guided in the right direction concerning design. In this light, and in order to help designers identify their ethical duties, many different solutions might be suggested. For example, we can set particular standards for hospitals in which the ethical needs of patients are considered.

This is an instrumental strategy; however, in addition to such standards, hospital designers need to have an ethical perspective so as to be led to concentrate on the ethical risks which threaten patients' rights in the hospital environment. This is because each hospital has unique characteristics and considerations which may not completely fit with the common standard of hospitals in general. In such cases, a moral designer, who is equipped with a proper ethical perspective, can identify the specific ethical responsibilities of his project.

However, if we over-emphasise standards and try to define a standard for every single issue in design, designers would be restricted in their job. Designers, as artists, need a certain amount of freedom otherwise they can lose the sense of creativity in their planning. Excessively detailed standards may limit their ability to provide for other relevant considerations – such as medical requirements, technical issues, aesthetic aspects of design, and so on. Instead of such excessively detailed standards, it would be better if we could give them some guidance by which they are able to identify their ethical obligations on their own. This guidance should make clear the ethical requirements relevant to the hospital environment whilst also allowing designers enough flexibility to provide the best environmental elements of design that are compatible with both the ethical requirements and other considerations.

Scholars and professionals may have different solutions for this requirement (i.e. identifying the ethical duties of hospital designers). For instance, it might be suggested that ethical arguments are pursued in order to figure out how designers should meet their responsibilities. However, any proposal of this kind needs to be well-established and explained in order that the relevant professionals can use those ideas in their work. My suggestion is to determine the

[5] In the next chapter, it will be clear that the hospital environment should respect the dignity of everybody (i.e. patients, relatives, visitors, and staff), and that it is not an exclusive right for patients.

ethical responsibilities of hospital designers by defining some key principles which are based on a philosophical theory. Through such a strategy we will find and establish an intellectual structure by which a hospital designer can find a general perspective about her ethical duties. Such an ethical viewpoint, as explained above, can help a hospital designer to focus on the main areas in which she can protect patients from losing their entitlements. Therefore, the core mission of this thesis is to find the main ethical principles for hospital designers.

As the notions of human dignity and patients' rights are discussed in various ways, the ethical framework of hospital designers should be able to answer the following questions:

- How should the concept of human dignity be understood in the context of the hospital environment and its design?
- How can the concept of human dignity determine human entitlements in a way which is sensible for hospital providers?
- What human entitlements can be affected by the hospital environment?
- And finally, how can hospital designers remove (or at least alleviate) the obstacles to achieving the main entitlements of people in hospitals?

To establish such an intellectual framework in which designers can find an answer for the above questions we need to ground our arguments in a suitable philosophical theory. Such a theory should be able to construct a link between the concept of human dignity and a practical understanding of human entitlements in hospitals. There are many theories and explanations which discuss human dignity and rights. Again, scholars may select some specific theory by which they can find an answer for the above questions. My hypothesis is that Martha Nussbaum's 'Capabilities Approach' is able to give us the direction we need in order to identify the ethical duties of hospital designers.

2.2. The Capabilities Approach

The Capabilities Approach was first proposed by the economist Amartya Sen (1933–). In philosophy, however, this theory is mostly known in the field of social justice, particularly through the work of the philosopher Martha Nussbaum. While Sen discussed his theory mainly from within an economics perspective, Nussbaum's philosophical attempts in developing her theory have particular advantages for this thesis, which will be mentioned in due course. The prominent benefit of Nussbaum's work is her suggested list of central entitlements (capabilities) which is instrumental in this thesis in determining the entitlement of human beings in hospitals. I will discuss Nussbaum's list of human entitlements in section 3.1.3.2.

The Capabilities Approach is also called the 'human development approach', however, Nussbaum prefers to name it the 'Capabilities Approach' because she considers the capabilities of both human beings and nonhuman animals in her theory (Nussbaum 2013: 17 – 18). The argument in her philosophical approach is that "a society is just to the extent that every citizen has constitutionally guaranteed entitlements to a list of basic capabilities" (Claassen 2014: 241). These entitlements emerged when considering the importance of human flourishing and freely striving activities. In other words, what is valuable in a human life is one's ability to practice one's capabilities. Accordingly, it is a human's right to have a sufficient opportunity to practice those capabilities. In this regard, a dignified human life is a life in which one can practice, at the very least, one's central capabilities[6].

Nussbaum's core arguments start with the notion of human dignity, and a life worthy of human dignity. She then moves her discussion to the basic entitlements of human beings in a just society. Nussbaum suggests a list of ten basic capabilities whose practise and development constitute the basic entitlements of human beings. In this way, her theory of justice links the two key notions, namely human dignity and human entitlements. This makes the theory considerably applicable in the context of hospital design in which the main ethical concerns are discussed with reference to these two conceptions (i.e. human dignity and human rights).

I have selected this theory as a guiding idea as I think that Nussbaum's Capabilities Approach can satisfactorily connect the two notions of human dignity and rights in a way that can handle the ethical concerns of the hospital environment. Using such an idea can help us to identify the ethical principles required of hospital designers. In chapter four, it will be explained how the Capabilities Approach of Nussbaum can direct us in finding those ethical principles.

Such ethical principles are supposed to be able to show the main areas in which patients' entitlements in hospitals might be undermined. Again, someone else may suggest other theories or ways by which the ethical responsibilities of hospital designers might be addressed, which should be welcomed. However, this is the way that I was able to determine the ethical principles of hospital designers within a theoretical framework, and my claim is that the suggested principles can guarantee an ethical environment in hospitals.

However, the Capabilities Approach has broad aspects and it is discussed in various fields such as social justice, global justice, healthcare economy, animal rights, and so on. My investigation, nonetheless, indicates that there are no systematic philosophical arguments in the context of the ethical design of hospitals. Since the mission of my thesis is to find ethical

[6] I will expand her thoughts about the list of capabilities in section 3.1.3.2.

principles for hospital designers, I need to enact a proper strategy when studying the Capabilities Approach in order to achieve the goals of this mission. In this light, and considering that the key notions concerning the ethical environment of hospitals in the literature is centred on the ideas of human dignity and rights, I think it is suitable to concentrate on these two notions in Nussbaum's theory in order to see both how they are connected together and how they can be brought into the context of the hospital environment and its design. In this way, we can provide a transparent understanding of human dignity and patients' entitlements in hospitals which is necessary in order for designers to identify their ethical responsibilities.

Thus, in this research I will focus on the role of the concept of human dignity in Nussbaum's Capabilities Approach. As will be mentioned, this is because Nussbaum begins and grounds her Capabilities Approach with the idea of human dignity. However, she does not address the different aspects of the notion of human dignity in one place, so we need to explore her writings to find answers to the important issues related to human dignity. Thus, in order to organise my arguments concerning her dignity, I need an argumentative platform upon which I can develop Nussbaum's ideas about human dignity.

For this purpose, I have decided to advance my arguments within a Kantian framework of human dignity. Kantian dignity is one of the most comprehensive and influential accounts of this notion. Therefore, elaborating the main elements of his account of dignity presents an opportunity to advance novel ideas concerning the main areas of human dignity; namely, the meaning, the implications, and the theory of human dignity. These ideas are either accepted, modified, or objected to by Nussbaum. Accordingly, having ascertained the position of Kant on the above main areas of human dignity, I can explain how Nussbaum deals with those areas. In addition, discussing Kant's notion of dignity can assist us in gaining a better understanding of the different aspects of this notion, as Kant's work on the topic has been well-discussed by many philosophers.

Therefore, I will begin my argument by explaining the Kantian account of dignity. Having this basis, I will consider some objections against the notion of human dignity in general, with a particular focus on the views of Ruth Macklin, and I will offer replies to them. With these arguments, I will have provided a basic picture of the concept of human dignity. I will then concentrate on Nussbaum's account of dignity and attempt to identify which aspects of Nussbaum's dignity are similar to Kant's, and which are not. I will show that the meaning of human dignity for Kant concerns 'value' and 'worthiness'. While Nussbaum does use this meaning of dignity in her work she also utilises dignity in another sense, which I will call 'dignity as decency'.

Nussbaum also tries to develop the Kantian implications of human dignity (i.e. respect for human dignity, human rights and duties, and equality). Having a more practical approach, Nussbaum determines ten basic capabilities of human beings which everybody should be able to practice so as to have a life compatible with human dignity. Subsequently, I will explain how the list of capabilities in Nussbaum's theory affects her arguments about the corresponding responsibilities and human equality. However, in terms of the theory of human dignity, Nussbaum disagrees with Kant: Kant believes that the source of human dignity is human autonomy of will. In contrast, Nussbaum holds that human beings are valuable in virtue of a range of capabilities to flourish through various forms of striving and activity.

With these investigations into the concepts of human dignity and entitlements in Nussbaum's Capabilities Approach, we can reach a suitable understanding concerning the two notions of human dignity and rights. The next step will be to bring these senses of dignity and entitlements into the context of the hospital environment in order to figure out how we can determine ethical principles for designers. Firstly, I shall begin my argument with an exploration of Kant's account of human dignity.

2.3. Kantian Dignity

The concept of dignity has a long history and in pre-modern times usually reflected the valuable status of elites in comparison with the ordinary people. In the current era, this notion has other connotations in common speech. These connotations of dignity have similar meanings to the notions of honour, nobility, and the like[7]. As well as its common uses, dignity has a considerable conception and role in both moral and legal discourses. The moral conception of dignity is the result of the attempts of a number of philosophers who apply this concept as a part of their ethical theories.

Among those scholars who brought the concept of dignity into their ethical theories, Immanuel Kant (1724 – 1804) has an eminent status. This is because his theory has most inspired and influenced later discussions of dignity (Rosen 2012: 19, Kerstein 2014: 222). Kant is, in fact, an artist in moralising the concept of dignity by clearly addressing the main questions of human dignity in an interconnected way. The three main areas of human dignity, in my opinion, can be explained by addressing the following questions:

1. What is the meaning of human dignity in a theory? How should we understand it? (I

[7] I will explain the different meanings of contemporary dignity in section 2.4.1.2.

will call this area of discussion the *meaning* of dignity.)

2. What does this account of dignity imply? What are the main elements of such human dignity? (I will call this area of discussion the *implications (or elements)* of dignity.)
3. For what reason does an individual have dignity? (I will call this area of discussion the *theory* of dignity.)

I do not believe that Kant's arguments are successful in all of those areas and, as I will elaborate, some aspects of his arguments face serious challenges. However, his attempt at connecting and discussing all aspects of human dignity in the form of a unified ethical theory is admirable. I think Kant's ability to link all of the above questions of human dignity within his ethical theory is why he provides a platform for the later discussions about this notion (whether in favour or against his conception of dignity; or, in favour or against different aspects of his theory and arguments). In this light, it is suitable to develop the Kantian account of dignity in this section. This will provide an appropriate basis upon which to elaborate Nussbaum's account through comparing the differences and similarities between these two accounts of dignity.

However, the Kantian account of dignity is complicated and there are many different interpretations of this theory. For example, contrary to many researchers who understand the essence of Kantian dignity as 'value', Sensen (2009) tries to show that dignity for Kant is about 'the elevation' of human beings over other things. It is beyond the scope of this thesis for me to deal with all of those discussions. This is because the arguments concerning Kant's account of human dignity are broad and involve many aspects.

The topic of this thesis is not, however, 'human dignity' per se. What I will try to do in this research is to address the core aspects of this notion which are necessary for developing ethical principles for hospital designers. Since this notion is essential for ethical considerations in the field of hospital design, I will also develop the relevant issues concerning human dignity. Therefore, while I admit that the philosophical issues related to dignity are much broader than what I will mention in these sections, given that I need to return to the main mission of this thesis – i.e. finding the ethical principles for hospital designers - I will leave more detailed discussions of these areas to other scholars.

In this section, I am going to briefly explain the Kantian account of dignity by investigating his view with respect to the three aspects of dignity – namely Kant's ideas about the meaning, the elements (implications), and the theory of human dignity. In this regard, I will mention some examples of the controversies surrounding those Kantian ideas in order to clarify the main issues concerning dignity, but I will refrain from covering further discussions and

objections due to the limitations of this research. (The main objections to Kant's account of dignity are centred on his theory of dignity. Therefore, I will briefly touch upon the main issues related to the meaning and implications of Kantian dignity, and discuss in more depth the objections against the theory of Kantian dignity).

I will say that the *meaning* of dignity for Kantian scholars is similar to the notion of 'value' and 'worthiness' which has characteristics such as inalienability, being incomparable, inherent, and unconditional. Even though value and worthiness are not completely incorrect interpretations of the meaning of Kantian dignity, I will suggest 'valuable status' as a more accurate conception which can better depict the meaning and the elements of Kantian dignity. As I will explain in a forthcoming section[8], the concept of human dignity has other valid meanings in common conversations that are not necessarily equivalent to Kantian dignity. Having said as much, we can unify all of the non-Kantian meanings of dignity by introducing the concept of dignity as 'decency' as the second conception of dignity, and still maintain a connection to the Kantian meaning that is simultaneously compatible with the arguments of Nussbaum.

Despite arguments against some aspects of the implications of Kantian dignity, as will be illustrated, I think its main elements (i.e. equality, human rights and duties, respect for human dignity) are significantly valuable, and have an essential role to play in the ethical and international legal documents. Nussbaum, also, takes advantage of the Kantian elements of dignity in her account, but with a more practical approach which is instrumental for this thesis, as will be discussed[9]. And finally, the main attacks against Kantian dignity concern his *theory.* It will be elaborated[10] that for Kant only those who have the (potential of) rationality have dignity. This theory is, rightly, objected to by many philosophers such as Nussbaum for excluding a group of beings (e.g. the severely mental ill) who are commonly regarded as dignity-bearers.

2.3.1. The Meaning of Kantian Dignity

What does human dignity mean for Kant? This is the first question that I will investigate. When we are talking about the meaning of dignity we should notice that the discussion is not simply about a term that can be interchangeably used as a synonym of dignity. The meaning

[8] See section 2.4.1.2.

[9] See section 3.1.

[10] See section 2.3.3.1.

of dignity, in fact, consists of a set of characteristics which are attached to the synonym word. In addition, the implications of Kantian dignity, in particular, can shape our understanding about the *meaning* of Kantian dignity.

To explain more, many near synonym words can be used in the definition of dignity, but it is important to notice that none of them alone can provide a complete definition, and that they may even convey different senses. Nobility, honour, self–esteem, worthiness, value, status and some other words are instances of synonyms of dignity which can, to some extent, reflect the essence of dignity. However, scrutinising the sense of each of these notions reveals the hidden differences between them. Dan–Cohen for example, elaborates the difference between dignity as honour and as worth.

> Honor and worth can be fruitfully contrasted along four dimensions: origin, scope, distribution, and grip. Honor is of social origin: it derives from and reflects one's social position and the norms and attitudes that define it; whereas worth, at least as used by Kant, has metaphysical origins: the alleged radical autonomy of the noumenal self. Consequently, honor is in principle limited in scope, capable of privileging only those who occupy certain positions while excluding others who occupy different ones; whereas worth has a universal scope, applying to every human being as such. Relatedly, the distribution of honor is typically uneven and hierarchical, reflecting and indeed in part constituting social stratification; worth is evenly distributed over humanity as a whole. Finally, the grip that worth has on its possessors (or, conversely, the grip they have on it) is much stronger than the grip of honor. Honor, is contingent, in the sense that it must be earned or granted, and so can be forfeited or withdrawn; whereas worth is categorical, attaching to all its possessors by virtue of being human, no matter what (2012: 4).

Accordingly, the definition of dignity depends on the approach of the philosopher and the way she introduces the notion. Hence, a philosopher who sees dignity in the framework of a moral theory (e.g. Kant) may prefer to select a synonym word which more than others can cohere with and help to comprehensively justify the rest of her theory. For Kant, as will be explained, these words are 'value' and 'worthiness'. But, some other characteristics and implications of Kantian theory will also come to clarify this sense of dignity. (Kant attaches at least four characteristics to 'worthiness' – namely being inherent, inalienable, unconditional, and of incomparable value.)

In the following passages, I will discuss these characteristics which altogether shape the meaning of Kantian dignity. After that I will talk about some essential *implications (elements)*

of Kantian dignity. By considering those implications, however, I will suggest that we define the Kantian meaning of dignity as 'valuable status', which I think is more accurate than merely 'value' and 'worthiness'; even though these two terms are not *wrong* terms in my point of view. In the following sections, I will also explain how the notion of dignity has some other non-Kantian meanings as well.

2.3.1.1. Dignity as Value and Worthiness

Dignity is used 111 times in Kant's published books (Sensen 2009: 310). The German word "Würde" in his writings is usually translated as dignity:

> The German word for dignity is *Würde*, a word that is closely related etymologically to *Wert*, the term for "worth" or "value." The adjectival form, *würdig*, means both "valuable" or "deserving"—as in "deserving of reward"— and "dignified." (There is a parallel here with Latin— *Domine, non sum dignus* —and English. "Worthy," which has, of course, the same root as *Würde*, has something of the same duality. We talk, for example, about "local worthies" or "dignitaries" as well as of "worthy winners") (Rosen 2012: 19).

Kantian dignity can be better understood if we first consider his overall theory in which dignity is a piece of the puzzle. (We should bear in mind that his theory itself is highly complex and, accordingly, many interpretations are rendered by philosophers. What I would like to mention here are only the headlines of his theory). The rational free will of human beings, which is determined by reason and is not motivated by inclinations, leads rational beings to the actions which have moral worth. The rational nature[11] of human beings can, in fact, legislate moral principles under a leading principle, namely the *categorical imperative*, that can be universally binding and involve seeing human beings as ends in themselves. Such a moral law determines the ends of action which are systematically connected together in the *kingdom of ends*.

In this framework, Kant in an oft—remarked upon passage from his *Groundwork of the Metaphysics of Morals*, describes dignity as an inner worth:

> In the kingdom of ends, everything has either a price or a dignity. What has a price can be replaced with something else, as its *equivalent*; whereas what is elevated above

[11] Rational nature, for Kant, is "valid only under the contingent conditions of humanity" (Kant 2002: 24).

> any price, and hence allows of no equivalent, has a dignity.
>
> What refers to general human inclinations and needs has a *market price*; what, even without presupposing a need, conforms with a certain taste, i.e. a delight in the mere purposeless play of the powers of our mind, has a *fancy price*; but what constitutes the condition under which alone something can be an end in itself does not merely have a relative worth, i.e. a price, but an inner worth, i.e. *dignity*.
>
> Now, morality is the condition under which alone a rational being can be an end in itself; because it is possible only by this to be a legislating member in the kingdom of ends. Thus morality and humanity, in so far as it is capable of morality, is that which alone has dignity (Kant 2012: 46 – 47).

In this famous statement, Kant presents the differences between dignity and price, and dignity is described as a kind of *worth*. Hence, the core of the sense of dignity for Kant is about 'value' and 'worthiness'. As we shall now see, such value has some specific characteristics.

2.3.1.2. Intrinsic and Inalienable Value

As quoted above, for Kant the concept of human dignity is an inner worth. It is important to notice that when something is inner and intrinsic, it means that the existence of that thing only belongs to the existence of its bearer, not to any other external causes. In terms of intrinsic dignity, thus, this means that the dignity of a human being exists so long as that human, as a rational being, exists and, furthermore, that external conditions have no effect on her dignity.

Being an *intrinsic* characteristic of human beings also means that nobody can remove the dignity of a person. Being intrinsic in this sense indicates that dignity is *inalienable* (Kant 1996: 187). This implies that the dignity of someone cannot be removed or changed by other things. Therefore, the social ranking of people, their ethnicity, race, religion, gender and the like cannot be the causes of the gifting or divesting of dignity. Not only can other people not remove or change the dignity of a person, but also the bearer of dignity herself is not (morally) permitted to ignore her own dignity. Everybody in every condition has dignity whether or not they want to possess it.

The inalienability (inviolability) of the Kantian sense of dignity, however, is criticised by some scholars. In the next section, I will explain that one of the objections against human dignity is that while Kant describes it as an inalienable value, the nuance of some (particularly) bioethical references indicates violability of dignity. This also happens in some common-sense

talk of dignity. For example, when a patient in a hospital complains of a lack of privacy, she may claim that her dignity is violated, or harmed. Therefore, the objection is that dignity is not always inalienable as Kant described it.

To reply to this sort of objection, some scholars clarify that the concept of dignity has some non-Kantian senses in which it is not inalienable. They claim, accordingly, that those terms of dignity in bioethical documents which are not compatible with inalienability of the Kantian sense, refer to non-Kantian senses of dignity. After an elaboration of such arguments in the next section, I will state my agreement with the fact that dignity has some non-Kantian senses which are not inalienable.

I will also show that these non-Kantian meanings of dignity can be united together in the moral discourse as a single sense which I call 'dignity as decency'. Consequently, I think we can have two ethical conceptions of human dignity: the prominent one is Kantian dignity which is inalienable and inspires many of the ethical deliberations in bioethical documents, and a secondary ethical notion which is not inalienable and therefore can address those cases in bioethical instruments which convey a violable sense of dignity.

2.3.1.3. Incomparable and Unconditional Value

Being above all prices also indicates that nothing can be substituted for dignity. Therefore, dignity in human beings is above every other human attribute. Dignity does not have any equivalent and cannot be exchanged with any other thing (Kant 1996: 209); thus human dignity is an *incomparable* value that cannot be calculated. The dignity of a person is not more or less than the dignity of someone else – or even a group of individuals. Moreover, this entails that nobody's dignity is privileged over that of anyone else. This is because if someone prefers the dignity of one person over another, then she is comparing their dignities. Consequently, for example, no one should be discriminated against, in terms of dignity and its requirements, on the basis of gender, race, and so on.

Human dignity is also an unconditional (absolute) characteristic in the Kantian account (Dean 2006:35). The unconditional nature of dignity means that dignity is not related to the qualities of the person, in that he or she has dignity whether or not they are a good person. The unconditional dignity of a human being also indicates that despite the events that can happen to a person, his value can never be damaged or reduced.

However, the incomparability of human value is challenged by some scholars. For example,

Kerstein (2014) claims that this characteristic is in some cases incompatible with common moral judgments. For instance, he provides the story of a soldier who sacrifices herself to save others. Having incomparable worth, it would not be acceptable if one sacrifices oneself for those with similarly incomparable value. If one gives one's life in a heroic action, this indicates that one evaluated one's value as less than others. Hence, while common moral judgement supports such heroic and admirable actions, they are not morally valid within a Kantian ethical framework[12].

Kerstein has also questioned the unconditional characteristic of human value. For instance, he depicts a case in which there are two patients – one young and one very old – both of whom need a certain kind of medicine to survive. There is only one dose of this live-saving medicine available. Kerstin states that the common judgement about this case favours giving the medicine to the young person. However, Kerstein explains that such a moral judgment is against the unconditional value of human beings, which implies that the value of human beings is not related to contingencies – such as being old or young, being bad or good, and so on (Kerstain: 2014: 226-227)

However, I am not sure if this objection of Kerstain undermines the unconditionality or incomparability of Kantian dignity. The case looks like one of 'tragic choice' where whatever is chosen involves something very bad (i.e. the death of a person). Thus, one might say that it is the incomparable and unconditional value of both patients that makes the choice a very difficult and tragic one in the first place; and that of course the choice has to be made on some other grounds (e.g. age), rather than on the relative value of patients involved. Therefore, not all acts of comparison between human beings necessarily implies a comparison between their value.

I think that the root of this sort of critique can be traced back to a more general debate between deontological and consequentialist doctrines in ethical discourse: the question of whether we can (or should) calculate the number of human beings (or their pain and happiness) involved in such cases, or not. Each side has its own pros and cons, which have been discussed over much time. Nonetheless, what is of importance for this thesis is to see if these two controversial characteristics of Kantian dignity can affect the ethical concerns in hospital design.

Hospital designers predict and provide for the facilities people *will* need in hospitals. This

[12] This objection is rejected by some scholars. For example, Thomas Hill (1980). However, as I will discuss below, I do not think that being unconditional or having incomparable value has a considerable effect on ethical issues in hospital design. Therefore, I will not unpack the different sides of these arguments.

means that at the time of designing and constructing a hospital it is not (usually) determined which specific person will use those facilities, nor whether or not the practise of comparison will take place in the hospital at all. The hospital environment is normally provided for future events and for anonymous people. Thus, a comparison between human beings, particularly comparing their value, is not something that occurs in the process of hospital design. Overall, discussions about these two characteristics of Kantian dignity – namely incomparability and unconditional value – do not have a major effect on the ethical design of hospitals.

2.3.2. The Implications (Elements) of Kantian Dignity

As explained above, the sense of dignity for Kant is about value and worthiness. This is an answer to the first question, namely what does dignity mean for Kant? The second question, however, concerns what such dignity implies. The implications of Kantian dignity are no less important than its meaning in understanding his conception of dignity. Moreover, these implications have a vital effect on the contemporary discourse in ethics and law and so should be considered as well. Among the implications of Kant's notion of dignity, however, I would like to underscore some central elements – namely duty and rights, respect, and equality.

2.3.2.1. Duty and Rights

Dignity for Kant conveys two central implications; *duty* and *rights*. Everybody deserves to be respected in virtue of their dignity, and at the same time has an obligation to respect the dignity of all other human beings (see especially, Kant 1996: 209). Thus, dignity has two sides: on the one hand, everyone has a legitimate claim (i.e. right) to be respected as a dignity possessor, and on the other hand, everybody has a duty to respect dignity possessors (including oneself). This implication plays a central role in my thesis, because what is crucial is to find the ways in which hospital designers can respect the ethical rights of people in hospitals. The Capabilities Approach of Nussbaum, likewise, focuses on a set of basic human entitlements without which one cannot live with dignity. Correspondingly, I will argue that designers have a duty to provide for such entitlements, and that we should seek to identify all of the moral duties of designers through which they can provide for the entitlements of human beings.

It is also worth mentioning that although human dignity brings rights as well as duties to its bearer, in some official documents the focus is not always balanced between these two sides. While liberal ethics (i.e. rights–side of dignity) emphasises the entitlements of human beings,

conservative ethics (i.e. duty–side of dignity) regulates their conduct. It is essential to take into consideration this kind of duality in the concept of dignity (i.e. duty and rights) in order to avoid misunderstanding the function of dignity in those documents. I will explain this further below[13]. All in all, Kantian dignity is about an intrinsic human worth that implies duty and rights.

2.3.2.2. Respect for Human Dignity

As mentioned above, people have a certain duty towards human beings as the bearers of dignity. Kant uses the concept of 'respect' for human dignity in order to describe such duty (Kant 1996: 209). This respect not only addresses the duty of people towards each other; human beings also have to respect themselves (Kant 1996: 187). The dignity of human beings is respected when persons are treated as *ends in themselves* and not merely as *means*.

> For rational beings all stand under the *law* that every one of them ought to treat itself and all others *never merely as means* but always *at the same time as end in itself* (Kant 2002: 51).

If we consider 'respect' as the presentation of our duty towards the dignity of other human beings, then to provide for the rights of dignity-bearers would mean to respect their dignity. Hence, I would interpret the ethical principles determined in biomedical documents as various instances or emergences of respect for human dignity. Respect for human dignity in one case may emerge as respecting the right to freely choose a course of treatment in hospital and to have one's consent sought; and in another case, may appear as the right of privacy, and so forth. Depending on different situations, respect for human dignity commands a relevant moral duty toward others.

In the light of these explanations, I would like to return to the point that I previously mentioned, that is, why in some cases in the international documents there are some notions which indicate the violability of human dignity. As I will explain in the next section, various concepts of dignity can have some notions of its violability which explain these cases. However, I think we can still interpret some of these notions using Kant's notion of inalienable dignity. The concept of protecting human dignity, which is widely reflected in the international instruments, is an example.

[13] See section 3.1.3.4.

For instance, in 1997 the Council of Europe published its Convention on Human Rights and Biomedicine. In the first article of this convention we read:

> Parties to this Convention shall *protect* the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine (Council of Europe, 1999, emphasis in original).

The concept of protection usually conveys a warning about the possibility of being affected by external causes, and the necessity of deterring such an effect. However, according to the Kantian account, human dignity is inalienable and it cannot be changed or affected by external causes. To explain these cases from within the Kantian framework, we can interpret these cases as referring to the failure to respect human dignity. Such failure to respect the dignity of others may occur through degrading, humiliating, discriminating, insulting and many other offensive actions. In Nussbaum's account of dignity, as will be explained[14], the failure to respect human dignity also includes not properly providing for basic entitlements.

2.3.2.3. Equal Human Beings

The last element of Kant's account of dignity that I would like to mention here is *equality*. As we have seen, for Kant, morality has dignity. Humanity, insofar as it is capable of morality, deserves to be attributed dignity. Therefore, from the Kantian perspective, what is worthy is not merely being a human as a mere creature, but the human capacity to legislate the moral law (i.e. being rational in that sense). Thus, in this view human dignity conveys the sense of *equality,* because all moral legislators (i.e. adult rational humans) have the same capacity.

Thus, morality is the worthy condition of all human beings which endows them a value above all other prices. This implication also plays an important role in the legal and ethical discourse. Equal dignity is also an important element in Nussbaum's Capabilities Approach, even though it needs to be modified in some respects. In section 3.1.5., I will discuss the role of equality in Nussbaum's conception of dignity.

The aforementioned elements (implications) of Kantian dignity have had a considerable impact on many of the later discussions of dignity. Some scholars may defend some other senses or theories of dignity, but they more or less utilise the implications of Kantian dignity in their theories. These *implications* are also essential in understanding the *meaning* of dignity.

[14] See section 3.1.2.

Without considering the above implications, we cannot grasp the essence of Kantian dignity. In my opinion, when the notion of dignity as an inalienable value of human beings is taken together with the conceptions of duty and rights, it gives a deeper understanding of dignity as an ethical and legal term.

In this regard, I think the implications of Kantian dignity lead us to think about a more *accurate* meaning of Kantian dignity. I think it is better to describe it as 'valuable status', even though defining it as value or worthiness is not wrong. In defining dignity as valuable status we put the emphasis on status whilst characterising it with the term 'valuable'. Dignity as valuable status, in my opinion, is more compatible with the duty–rights feature of dignity than defining it as value or worthiness.

To explain further: consider the following. If, for instance, one wants to replace the word 'dignity' with 'value' in the following sentence:

> 'Since human beings have dignity, they have certain duties,'

The sentence would change to:

> 'Since human beings have value, they have certain duties.'

The first sentence looks acceptable because it is compatible with the common understanding of dignity. However, I am not sure that I can make the same claim for the latter. This is because, when we describe something as a valuable or worthy thing, it is expected that we protect or respect it. For example, it is expected that we protect an expensive diamond because it is valuable; therefore, we keep it in a safe place (for protection) or we use it in a valuable thing such as a king's crown (out of respect). Similarly, if we attribute value to a person, then she would feel that she deserves to receive respect rather than accept a duty; she feels she has a sort of *right*. In fact, the concept of value rather highlights the rights–side of dignity more than both rights *and* duties.

From this point of view, the implication of duty to others appears *only* when we consider that other people have the same value, and thus, everybody has, at the same time, a duty to respect the rights of others. Therefore, if we describe human dignity as worth, we need such extra explanation to justify duty as an implication of dignity. Hence, even though it cannot be said that defining dignity as worth does not imply duty, value and worthiness *per se* (i.e. without considering the fact that all human beings have the same rights) it cannot so clearly convey the sense of duty.

In contrast, the concept of status implies both rights and duties. The status of a person allows

her to benefit from a certain set of rights, but also brings a set of duties. For example, a police officer, because of her status, can have a right to command drivers and, at the same time, can have a duty to help prevent traffic congestion. Therefore, I think that the concept of valuable status is more suited to describe Kantian dignity rather than mere value alone; both rights and duty can be understood with the same level of importance.

2.3.3. The Theory of Kantian Dignity

One of the main aspects of discussions of dignity concerns the *theory* of human dignity: for what reason does one have dignity? Not all philosophers are successful in addressing this question. Some thinkers do not even have a clear theory for their ideas about human dignity. For example, as I will explain in section 2.5.3., Jeremy Waldron (2012) claims that the contemporary understanding of human dignity is, in fact, a transvalued form of the old sense. The pre-modern conception of dignity has a hierarchical meaning, which has now been enhanced into an egalitarian sense. However, it is not clear why all human beings should have such high-ranked status in his theory (Neuhäuser, Stoecker 2014: 307). In the following, I will elaborate the Kantian theory according to which human beings have dignity in virtue of their rationality. By addressing some objections against his theory, I will show that the Kantian theory is the weakest aspect of his account of human dignity.

2.3.3.1. Human Rational Nature

For Kant, the source of (or reason for) human dignity is being a "rational being with autonomy of the will" (Hill 2014: 217). Rational beings have the capacity to conceive of or to legislate some principles of the will (i.e. 'imperatives'). Such principles can be influenced by external causes and be associated with desire. These sorts of principles are called *hypothetical imperatives* by Kant. For example, 'do not steal things if you do not want to go to prison' is a hypothetical imperative. The goal (or the desire) for not stealing is to avoid going to prison. Therefore, if somebody does not care about going to prison, she does not have a reason to avoid stealing.

However, moral principles, in Kant's view, are absolute and cannot vary for different people or under different conditions. In contrast to hypothetical imperatives is the categorical imperative, which is the fundamental moral law. Regardless of external causes, rational beings are able to legislate categorical imperatives which are moral principles. Kant suggests some

tests that maxims[15] have to pass in order to be categorical imperatives. For instance, he describes one of these tests as "act according to maxims that can at the same time have as their object themselves as universal laws of nature" (Kant 2012: 49).

In Kant's view, all human beings are able to recognise and will these moral principles, in virtue of being rational. A rational being, thus, is autonomous as she is capable of legislating such self–imposed moral principles without being causally determined to do so, for instance, by fear of punishment, desire for approval, blind acceptance of tradition and the like (Hill 1991: 29). Kant uses the term of "heteronomy" as the opposite of autonomy to distinguish wills which are influenced from external causes and principles which come from a categorical imperative (see particularly Kant 2012: 52).

For Kant, morality, which is above all price (i.e. has dignity), can only involve autonomous actions. Because of this, Kant says "*autonomy* is thus the ground of the dignity of a human and of every rational nature (Kant 2012: 48, emphasis in original)." All in all, practical rationality of the sort associated with autonomy is the only basic condition for recognising creatures as beings with dignity.

2.3.3.2. Problems for the Kantian Theory of Dignity

Although rationality is one of the distinctive characteristics of human beings, this claim that "humanity, in so far as it is capable of morality, is that which alone has dignity" is objectionable. It seems that, for Kant, only rational moral agents have ethical status. According to a strict interpretation of the Kantian view, we should exclude not only animals but also some groups of human beings from the list of dignity-bearers, such as infants, children, and people with severe mental illness. Regan depicts our duties towards non(-active)-rational beings under such a strict interpretation as follows:

> All that can be said about our moral dealings with such humans is that our duties involving them are indirect duties to rational beings. Thus, I do no moral wrong *to a child* if I torture her for hours on end. The moral grounds for objecting to what I do must be looked for elsewhere – namely, in the affects doing this will have on my character, causing me, so Kant's view supposes, to become "hard" in my dealings with human moral agents (Regan 2004: 182, emphasis in original).

[15] Maxims are proposed motivating rules for action, such as "always pay your debts".

Although Kant does not address these cases explicitly, since the focus of Kantian dignity is on humanity, it is highly likely that Kant would attribute moral status to, at least, infants and children "by virtue of their *potential* for moral agency" (Warren 2000:102, emphasis in original). Warren states that we can understand this point if we bear in mind that, for Kant, the humanity of bad persons is still valuable (ibid.). Yet, even we accept the above interpretation of Kantian dignity there are still some groups of people who are exempted from being dignity-bearers, such as people with severe mental illness. These groups of people have lost their rational agency, and there is little chance to retrieve their rationality. Since there is no hope that they can become rational agents again they do not have the potential of rationality which, from the Kantian perspective, means that they do not have dignity. The problem is that the reason for (or source of) human dignity suggested by Kant (i.e. a rational nature) cannot cover human beings in marginal cases.

Philosophers (mainly) take two kinds of approach to address this failure of the Kantian theory of dignity: some try to keep faith in believing rationality to be the *sole* source of dignity, and then, endeavour to modify it in such a way as to maximise the inclusion of groups of human beings as dignity-bearers (for example, by referring to the potential for rationality, as Warren suggests above). It seems to me, however, that they ultimately fail to render a comprehensive formula for *all* human beings. In the second approach some philosophers suggest retreating from the only-rationality-criterion formula and instead recognise some other capabilities as fellow sources of dignity. Some of these theories are, in my opinion, more successful at providing an inclusive account of dignity, even though there are some subtleties which shall be discussed and developed. In the following sections, I will mention some relevant arguments concerning them.

2.3.3.3. Modifying the Kantian Theory of Dignity

In the rationality-modifying approach, John Rawls, as an example, presents a formulation to solve this problem for the Kantian theory of dignity. "Moral persons", in his modified Kantian perspective, are "rational beings with their own ends and capable of a sense of justice" (Rawls 2009: 11). To reach equality in his theory of justice as fairness, he suggests that 'a certain minimum' should be 'generally fulfilled' (Rawls 2009: 445). By incorporating the 'capacity' of minimal requirements into the definition of moral personality, in Rawls' point of view, infants and children would be seen as moral agents (Rawls 2009: 445-446).

Even though this solution may address the dignity of 'infants and children' it gives the impression that we need to admit, subsequently, a kind of dignity for "fertilized or unfertilized

human ova—which also have the potential" (Warren 2000: 105). However, Warren holds that this concern can be replied to by the proponents of the only-rationality-view by reminding us that "persons are conscious beings, entities that have the capacity to have experiences, and not merely the potential to develop that capacity at a later time. Thus, it might be suggested that a person is a conscious being who is either actually or potentially capable of moral agency. This definition of personhood blocks the admission of human ova and presentient foetuses, while admitting infants and young children, and possibly third-trimester foetuses, which may already be sentient" (ibid.).

Nonetheless, again, even if we accept the above interpretation of Kantian dignity, there are still individuals who lack the potential for rationality, and who ultimately do not have moral status even on this modified version of the account. In this regard, Rawls admits that moral personality is the sufficient (and not necessary) condition for beings entitled to equal justice (Rawls 2009: 442). Although Rawls endeavours to cover the mentally impaired in his just society by offering some pragmatic reasons, mentally and physically impaired people deserve to be considered as dignity-bearers in virtue of their being humans (Freeman 2007: 287).

In fact, Rawls' interpretation of Kantian dignity has fallen short of giving an adequate theory of dignity, by which *all* human beings are considered as dignity-bearers. Rawls is not the only person who tries to give a modified account of Kantian dignity. There are also other suggestions concerning the theory of dignity, in which philosophers strive to modify the Kantian account of dignity. I would like to mention Allen Wood's suggestion for modifying the Kantian criterion of human dignity as another example. According to his idea:

> […] in order properly to respect rational nature, we are required to treat some beings who are not persons in the strict sense in certain respects just exactly as if they were persons in the strict sense. Or, to put it another way, we are required to accord, at least for certain purposes, a status equivalent to personhood to some beings that simply are not persons in the strict sense. For instance, we should treat small children as having a right not to be killed, to have their well-being looked after, and their development toward maturity cared for. I propose that we apply the term *persons in the extended sense* to beings that are not persons in the strict sense but that should be granted a moral status (in the relevant respects) exactly like that of beings that are persons in the strict sense (Wood 2008: 96-97, emphasis in original).

In this suggestion human children do not in fact have dignity but, in order to respect rational nature, other humans have to treat them *as if* they have human dignity. However, Wood holds a confusing position with respect to accepting or denying the moral status of children, exactly

like (rational) adults (Dwyer 2010:109). From my perspective, this problem is rooted in the question of theory: what characteristic of 'persons in the extended sense' requires us to respect them as if they are persons? This characteristic cannot be 'being human', as with regards to this characteristic children and adult humans are the same. It cannot be something inherent in these particular non-rational beings, too; it should be sought in their relation to other rational beings.

Kerstein assumes that such a relation is to be found between the child and those who aim to promote that child's flourishing (who would themselves be disrespected if this aim was hindered), such as the child's parents. Having made such an assumption, Kerstain refutes Wood's idea by referring to children for whom nobody has such an aim, and who therefore would be in no need of respect as no rational being would be disrespected by ignoring them (Kerstain 2014 225). However, I think, there is another imaginable alternative: respecting the child for the sake of the dignity of the moral agent as one would disrespect oneself if one disrespects a child. In other words, one may enact a form of respect for one's own dignity by respecting a child; whether or not that child has anybody who is concerned for her.

However, this case once again raises the question that I posed at the beginning of this argument: why should a moral agent respect a being (i.e. a child) who does not have dignity, and why should that agent not do the same to other things (e.g. a piece of stone)? (Remember that, according to Wood, we do not find the valuable characteristic – i.e. rationality – in 'persons in the extended sense' which would demand that they be respected for *their* own value). Consequently, Wood's proposal for modifying the Kantian theory of dignity does not look sufficiently justifiable either. The same problem exists in Hill's justification of Kant's theory of dignity:

> […] the thesis that ordinary competent adult moral agents have dignity by virtue of their rational autonomy does not imply that *only* they have moral value or standing. Moral principles are constraints and guides that ordinary competent agents *would* follow *if* they were fully rational and autonomous. The question is how such principles direct morally competent agents – those with the active capacities and dispositions of rational autonomy – to treat young children whose moral capacities remain latent, demented adults who have lost them, and animals that lack them. Arguably, these moral principles would require us to extend a kind of dignity to human beings who have lost or not yet developed moral capacities and also (despite what Kant says) to regard animals as more than mere means to our ends (Hill 2014: 218, emphasis in original).

In this interpretation of the Kantian theory of dignity, Hill strives to include young children, the severely mental ill, and animals in the list of dignity-bearers by extending a 'kind of dignity' to these groups of beings. However, I believe that Hill's suggestion does not actually address the question of the theory of dignity. This is because if such a group of beings (i.e. young children, etc.) have (a kind of) dignity, it means that they have an incomparable value which is above price, from the Kantian perspective. If they do have such incomparable value, then their value would not be something less than a rational being's.

Accepting these points, however, shows again the void in Kant's answer to the question of the theory of dignity: in virtue of what does one have dignity? The answer to this question for Kant is 'rationality', but we already supposed (in Hill's suggestion) that those groups of beings (i.e. young children, animals, etc.) are not rational agents. In fact, in Hill's suggestion, we attribute (a kind of) dignity to some non-rational beings without finding the source (or reason) for our considering someone as a dignity-bearer.

2.3.3.4. Multi-Capabilities Approach to Dignity

Overall, according to the Kantian theory of dignity, at least, some groups of human beings (e.g. the severely mentally ill) and non-human animals do not possess dignity. This problem is particularly important to me because my thesis is in the context of bioethics where ethical concerns of 'marginal cases' are important. There are plenty of situations in hospitals in which the status of the rational agency of patients might be, more or less, (permanently) questionable. There may be other kinds of human association where the idea of a 'kingdom of ends' (composed entirely of rational agents) is more straightforwardly applicable; but hospitals are not one of them. Consequently, this failure of the Kantian theory of human dignity is not an ignorable matter in my thesis, and I need to find a suitable alternative theory of dignity.

To avoid this Kantian problem of human dignity, some philosophers have taken another approach. They pose the following question: why not consider dignity as existing for human beings as empirical beings with a range of other characteristics (Spiegelberg 1970: 50)? As was mentioned, the source of Kantian dignity (i.e. rationality) has an absolute and abstract feature which can never be impacted on by external causes, while the real lives of human beings are extremely vulnerable and dependant on the natural world:

> […] for Kant, human dignity and our moral capacity, dignity's source, are radically separate from the natural world. Insofar as we exist merely in the realm of nature, we are not ends in ourselves and do not have a dignity; things in that realm simply have

a price (Nussbaum 2006: 131).

Nussbaum has taken a multi-capabilities approach in her theory of human dignity, in order to address the value of impairments and disabilities. As will be elaborated[16], instead of merely relying on rationality she suggests considering the animality of human beings as the source of dignity. (Animality includes a set of capabilities, one of which is rationality). Therefore, in her account of human dignity, not only is there no such problem of marginal cases, she even sees the needy aspect of human beings as something valuable and in need of support. This feature of the Capabilities Approach, alongside some other advantages which will be explained in a forthcoming section, encourages us to follow her theory of human dignity. This is because considering the vulnerability of human beings, and their dependence on the help of others, is exactly the kind of matter that a hospital designer should consider in her planning.

In summary of this section: there has been widespread discussion both in favour and against the Kantian theory of human dignity, each side of which has its own advantages and disadvantages. The attempts in these debates are to find the reason for (or source of) the dignity of individuals. However, Kant's theory fell short of covering those who lack the potential of rationality[17]. In general, I think, a theory of dignity is successful if it can, at least, cover *all* human beings. This is the common understanding of human dignity as valuable status and a theory of dignity should be able to address this issue. The main failure of Kant's account of dignity is that it cannot attribute this characteristic to all human beings.

In the future[18], I will explain that the concept of dignity in its common meaning *also* has some senses other than the Kantian meaning of dignity (i.e. dignity as valuable status). However, what is common to all those senses is a hidden conception of 'comparison' in the notion of dignity. Whether we consider dignity as value, worthiness, nobility, honour, or any other synonym terms, dignity indicates that there is something *praiseworthy* in the dignity-bearer which *elevates* the dignity-bearer above the other things which do not possess that praiseworthy thing; this is the sense of 'comparison' which I believe is inherent in all

[16] See section 2.6.2.

[17] Kant's theory about human dignity has another controversial aspect: the dignity of animals. Some philosophers, such as Nussbaum, believe that animals have their own types of dignity. This idea is not apparently compatible with Kantian dignity, even though some scholars such as Tom Regan (2004) adapt a Kantian framework to ground duties to animals with reference to the idea of a 'subject of a life', instead of rational autonomy. Unfortunately, I do not have space in this thesis to go into his theory in any detail or into his discussions of animal dignity. For a useful critical discussion of Regan see Julia Tanner (2009).

[18] See section 2.4.1.2.

conceptions of dignity. It impels us to attribute value and worthiness to the dignity-bearer in *comparison* with the other things. Discovering the reality of that praiseworthy thing in dignity-bearers is the appealing target, which encourages philosophers to render their own accounts of dignity; accounts whose aim is to identify that praiseworthy thing and to show whether or not all those who are known as dignity-bearers have that praiseworthy thing.

As explained above, the praiseworthy thing in the possessor of dignity, for Kant, is rationality. However, his theory is not successful at delivering the other mission of an account of dignity (i.e. to cover all human beings as dignity-bearers). For Nussbaum, however, the praiseworthy thing in dignity-bearers is the animality of human beings which includes rationality as well as sociability. I will explain Nussbaum's account of dignity later in this thesis[19].

2.4. Macklin's Objection

2.4.1. General Objections Against Dignity

Above, I attempted to explain the Kantian account of dignity. This explanation was based on three main areas of human dignity, namely the meaning, the elements, and the theory of human dignity. It was elaborated that the meaning of dignity, for Kant, concerns human value, which is inner, inalienable, unconditional, and incomparable. Dignity also has some important elements such as human rights and duties, respect, and equality. I also mentioned some of the objections against the Kantian theory of dignity in which one possesses dignity if one is (at least potentially) a rational agent. Despite the criticisms against Kantian dignity, the above explanation gives a basic understanding of this notion.

Such an understanding can now assist me in explaining the different aspects of Nussbaum's conception of dignity. However, before I start to elaborate Nussbaum's account of dignity, it is worth discussing some of the general objections against the concept of dignity. I will consider objections in the context of bioethics as this is more relevant to my arguments. There are some considerable lines of thought which hold that the concept of human dignity is 'useless' or even 'dangerous'. Before I develop Nussbaum's view of dignity, I need to address such objections in this section.

[19] See section 2.6.2.

The idea of human dignity in bioethics is still being developed and plays an increasingly crucial role. The emergence of the concept of dignity in some recently suggested ethical principles indicates that the status of dignity is strengthening in current bioethics. For example, in a former set of moral principles, autonomy, beneficence, non–maleficence and justice had ruled supreme (Beauchamp, Childress 1979). In more recent discussions, however, dignity stands as one of the main ethical principles. For instance, dignity is placed alongside autonomy, integrity, and vulnerability in one account (Rendtorff 2002) and with autonomy, justice, beneficence and non–maleficence in another account (EGE 1999: Ethical Aspects), and is suggested as one of the main ethical principles. Some authors such as Haugen even suggest dignity as the core of healthcare ethics (2010: 212).

Nevertheless, the concept of human dignity in bioethics, as with many other ethical notions, has faced challenges. Franz Josef Wetz sees dignity as "fake solutions for deep conflicts" which has "a very dubious role in contemporary bioethical discourse" (quoted in Schroeder 2008: 230). Steven Pinker (2008) in his *The Stupidity of Dignity* believes that dignity can even be dangerous. The serious war against dignity in bioethics, though, was started by Ruth Macklin (Conley 2013: 19). Macklin, who is a professor of biomedical ethics, refuses to accept that "dignity" is a useful principle.

She argues in an influential paper that dignity is an arbitrary concept within the bioethical context. In particular, she states: "[a]ppeals to dignity are either vague restatements of other, more precise, notions or mere slogans that add nothing to an understanding of the topic" (Macklin 2003: 1419). Macklin posits that, notwithstanding some exceptions, international documents do not specify medical fields. Referring to one of those exceptions (i.e. the Council of Europe's convention), she claims:

> In this and other documents "dignity" seems to have no meaning beyond what is implied by the principle of medical ethics, respect for persons: the need to obtain voluntary, informed consent; the requirement to protect confidentiality; and the need to avoid discrimination and abusive practices (Macklin 2003: 1419).

Tracing back the historical origins of dignity in bioethics, Macklin tries to show that "dignity seems to be nothing other than respect for autonomy" (Macklin 2003: 1419). Macklin suggests that the numerous references to dignity in religious sources have resulted in the frequent usage of this notion, particularly within medical ethics, and that dignity has crept into the secular literature of this field of study from those sources (Macklin 2003: 1420).

From Macklin's perspective, as an expert of bioethics, dignity should have no room in the context of medical ethics. Macklin is not alone in criticising dignity, even though she is the

most famous proponent of this view. In reviewing the main criticisms of dignity it appears that we can classify them into three kinds (particularly for the discussion in the field of medical ethics): (1) respect for human dignity is actually a re-statement of respect for autonomy (or respect for the person as an autonomous being); (2) human dignity is a vague concept which adds nothing; (3) if human dignity is inviolable (as human rights and bioethical documents hold, and as Kant claimed), why do we, for some inappropriate conditions of patients, talk about the violation of dignity (e.g. lack of privacy)?

Following Macklin's objection, many arguments have been rendered by doctors and nurses in response, some of which refer to the concern that "dismissing dignity risks disregarding the ultimate rationale for respecting each patient as a unique and irreplaceable person" (Andorno 2011: 267). However, the main arguments against the three principal criticisms mentioned above are offered through two strategies. In the first one, advocates of dignity try to reject the belief that respecting dignity is the same as respecting autonomy. Obviously, this sort of reply is appropriate in addressing the first kind of criticism aforementioned.

In the second strategy, however, responders to Macklin do not explicitly deny that respecting dignity, in the general sense, is equal to respecting autonomy. Instead, they identify some other meanings of dignity which on one hand are not inalienable characteristics of human beings, and on the other hand have more concrete functions. This strategy is mostly suitable to deal with the second and the third criticisms. To address the three kinds of criticisms against dignity, therefore, we need to consider both strategies.

In the following passages, I will consider the three kinds of objections. I will illustrate that 'respect for human dignity' *is* something beyond merely 'respecting human autonomy', or 'respecting an autonomous person'; even according to Kant's conception of dignity. I will also, however, admit that the concept of human dignity is, to some extent, vague. I will argue that this vagueness is not because it is a poor conception; rather it is because of its richness. Therefore, the vagueness of human dignity does not make it 'useless'; we should rather see this concept as a general idea, or a doctrine which can lead us to consider some important aspects of human life.

And finally, I will explain that the concept of human dignity does not merely have a Kantian meaning. Those bioethical documents which use a sense of human dignity implying its violability can be seen to be referring to non-Kantian senses of human dignity. However, in the next section, I will challenge the way these non-Kantian meanings of human dignity are described. Subsequently, I will suggest that we consider one of the meanings of human dignity as 'decency'; a sense which has a basis in Kantian dignity, and is utilised by Nussbaum in her

literature.

2.4.1.1. Dignity is not Autonomy

As mentioned before, the Kantian concept of dignity is one of the most influential descriptions of dignity and is reflected in many resources including international human rights documents, many national legal systems, and the like. Considering the fact that dignity for Kant is grounded in autonomy, it is highly likely that the capability for rationality and for choice-making is the core notion of dignity discussed in such ethical and human rights instruments.

The thoughts of more recent philosophers, in which autonomy is counted as an essential part of the description of dignity, underscores the deep connection between these two conceptions[20]. Perhaps such a profound link in "the tradition of thoughts explain[s] why critics like Macklin have come to regard the ideas of autonomy and dignity as being essentially synonymous with one another" (Neal 2014: 28). But repliers to Macklin have tried to illustrate that even though dignity and autonomy are connected, they are ultimately distinct (Neal 2014: 31).

There are a number of ways of addressing this issue (i.e. that respect for dignity is ultimately distinct from respect for autonomy) that I will briefly mention. The first one tends to be presented by those who are treating patients; and hence they argue according to their personal experience. In this light, they emphasise that dignity cannot simply be equated with autonomy as there are many cases in which one may be treated with respect for one's autonomy, but without sufficient respect for one's dignity. Taylor (2003), for instance, says: "I have seen many times an informed consent filled out by patients treated with little dignity".

However, my focus is on analytical responses to Macklin. Such responses reflect the problem we have already found with the notion of Kantian dignity: the problem of the dignity of non-rational human beings. It is widely accepted that even those who lack sufficient autonomy still have dignity. Therefore, if we equate respect for dignity with respect for autonomy, we may forget the ethical status of 'marginal cases', as discussed in section 2.3.3.2. Therefore, respecting dignity in medical issues involves a wider range of ethical concerns than merely respecting autonomy.

[20] See Mary Neal (2014: 28) for some recent examples of describing dignity by referring to the notion of autonomy.

If we depart from the Kantian notion of autonomy[21], we can also consider another characteristic of dignity which discourages us from equating respecting dignity with respecting autonomy. It has already been discussed that when one respects the dignity of others one, in fact, respects one's own dignity too. In other words, if one violates the dignity of others, one violates one's own dignity: it would be against my dignity if I did not respect the dignity of others.

But, we cannot claim the same for autonomy: one can violate the autonomy of others autonomously. More interestingly, one may deny the autonomy of others in the name of human dignity. As will be explained, dignity has a dual function: dignity sometimes acts in such a way as to empower freedom of choice, but it also sometimes constrains the freedom of agents (i.e. people are, sometimes, prohibited from engaging in actions that go against their dignity)[22]. Therefore, it would not be accurate to equate respecting dignity with respecting autonomy.

This section's final point against Macklin's position is identified in the below argument from Killmister (2010: 164):

> to respect an individual's autonomy requires respect for their self-governance. This is why the connection between autonomy and informed consent is so tight. To respect an individual's dignity, meanwhile, requires respect for their self-worth. Admittedly, as this self-worth can be undermined through failing to uphold principles, there is an overlap with autonomy. Nonetheless, there are numerous ways in which failure to respect self-worth is not synonymous with failure to respect self-governance. For example, when patients recount the experience of overcrowding as a violation of dignity, it is difficult to read this as a violation of self-governance, except in the thinnest possible sense that it goes against her wishes.

In many cases in which a person feels their situation is not 'decent' for her, she would claim

[21] For Kant (on standard interpretations) one cannot autonomously violate the autonomy of others. For him one is truly autonomous *only* when acting for the sake of moral duty and one ought never to violate the autonomy of another person (it is always morally wrong to treat another only as a mere means). Thus, if one freely permits others to treat one as a mere means, then the violators are not acting autonomously. This can in fact be considered one of the flaws of the Kantian account of dignity and autonomy: The Kantian autonomous agent is a moral agent when she acts for the sake of universal moral laws – categorical imperatives – that can bind the wills of all rational agents whoever/wherever they are. However, as I explained before, I do not adopt the Kantian account of dignity and autonomy in this thesis.

[22] For more discussions see section 3.1.3.4.: discussions about dignity as empowerment and constraint.

that remaining in that situation is beneath her dignity. However, remaining in such situations would not affect her respect for her autonomy. In the case of overcrowded wards, for instance, a patient may find her situation beneath her dignity but feel no violation against her autonomy.

It is also noteworthy that, in this kind of criticism, when it is said that respect for dignity is similar to respect for the person, the focus is mostly on the 'autonomy' of the person. Therefore, the main response given to critics, in this regard, is mostly to refuse to equate 'dignity' with 'autonomy'. However, it seems even 'respect for the person' cannot be a proper substitute for 'respect for dignity'. This is because, according to the Kantian perspective, the dignity of human beings is respected when persons are treated as an end and not merely as a means. It might seem strange to talk of 'respecting a person only as a means', but it is something that happens very frequently, such as when people are viewed only as sources of income or as customers. Thus, if someone respects a person merely as a means then she fails to respect her dignity. This means that respect for dignity is not simply respect for individuals.

A hospital designer, for example, who considers patients only as customers and as a source of income, may try to design the hospital in such a way as to ensure that patients are respected (as individuals). Such respectful design is adopted to attract more patients to hospitals and, consequently, raise hospital revenue. However, such a designer does not respect the dignity of patients (in Kant's terms), as she considers them merely as a means, even if in doing so she otherwise provides for their ethical concerns. The Kantian interpretation of respect for human dignity, in contrast, invites designers to see patients at the same time as ends through considering any other elements of design which can support patients, even if this does not increase hospital income. Consequently, contrary to Macklin's claim, respect for human dignity is "over and above respect for persons or for their autonomy".

2.4.1.2. The Vagueness and Inviolability of Dignity

The reasons elaborated above are given to reject equating dignity with autonomy, namely the first kind of criticism (i.e. dignity is a restatement of respecting autonomy or persons as autonomous beings). However, some philosophers have taken another strategy in responding to objections against dignity which is suitable for the second and third kinds of criticism. In this strategy, repliers do not insist on refusing to accept that dignity is equal to autonomy. Instead, they endeavour to demonstrate that the concept of dignity has more than one sense. Accordingly, both sides of the debate are correct in their arguments because they are addressing different issues: while critics are using dignity in the general fashion applied in the international policies of bioethics, the defenders of dignity are "concerned with dignity in the

particular sense of treating individuals in a dignified fashion" (Capron 2003).

Although I believe that those who take this second strategy overlook the arguments that deny an equivalence between dignity and autonomy (even in the general and abstract sense), I agree with them on this point: considering other meanings of dignity can help to elucidate important aspects in the debate about human dignity. Discussing other meanings of dignity can also help me in developing my arguments about Nussbaum's Capabilities Approach, in which I will argue that the central meaning of dignity concerns having a 'decent life' rather than a 'valuable status'. In the following passages I will discuss some of the arguments of this second strategy and, subsequently, I will suggest the definition of dignity as 'decency' in the next section.

One of the main oppositions against the concept of dignity in bioethics concerns its vagueness. The ambiguity of dignity in bioethics even causes the notion to be used in contradictory ways[23]. The role of human dignity in the discussions about euthanasia is one of the best examples. On the one hand, The World Federation of Right to Die Societies (2017) with members of organisations from all around the world has appealed to the concept of human dignity to affirm the right to die for competent adults. On the other hand, however, euthanasia and physician-assisted suicide is opposed, surprisingly again, in the name of dignity: "the choice to kill an innocent human life, whether one's own or another's, even for the sake of avoiding terrible suffering, is intrinsically immoral. Euthanasia and suicide are contrary to the intrinsic dignity of human persons" (Lee 2001).

Accordingly, it may be claimed that "if the concept is so vague that it can be used to defend opposing positions, so it should [be purged]" (Schroeder 2008: 232). To reply to this concern, dignity advocates make two points. Firstly, notion of human dignity, particularly in the abstract meaning of 'worthiness and valuable status', is not in this respect very different from other general principles:

> As a matter of fact, defining dignity in clear-cut terms would be as difficult as defining 'freedom,' 'justice', 'solidarity', or whatever other key social value (which by the way are never defined by law). It is not because the idea of human dignity is too poor, but because it is too rich that it cannot be encapsulated into a straightforward definition with which everybody agrees (Andorno 268).

This might account for the fact that it is employed as an overarching principle alongside human rights (e.g. privacy, confidentiality) in certain bioethical documents. Therefore, the vagueness of dignity is not typically taking as a reason to reject it. Instead, we need to use such a rich

[23] See for example de Melo-Martín (2011).

concept carefully, and explain the weak aspects of this vagueness rather than denying the whole concept: "dignity is a slippery idea, but it is also a very powerful one and the demand to purge it from ethical discourse amounts to whistling in the wind. It is better to try and eliminate some of its slipperiness than to ignore its supremacy in everyday morality and national and international law" (Beyleveld, Brownsword 2001: 63).

In fact, the concept of dignity should not be seen as a principle which can practically guide ethical concerns in medical ethics. *It rather should be considered as an idea, a doctrine, or a belief*: a belief that all human beings have an inherent worth and value, which is inalienable and equal, that brings rights and entitlements, as well as duties, and should be respected as an end and not merely as a means. All of these ethical values are encapsulated in a single notion: human dignity.

Accordingly, the recognition of and emphasis of the concept of dignity serves to illuminate the overarching doctrine which dominates fundamental discussions about people's rights in hospitals; that all people who are involved in a process of treatment (whether they are patients, doctors, etc.) have such intrinsic value and that this is what makes them entitled to decent conditions and opportunities. In this regard, dignity does not address biomedical issues in a practical way, rather, it guides us to set up our medical services according to this belief concerning the value of human beings and their entitlements.

As the second part of the response to the criticism of dignity as vague, repliers highlight the fact that dignity has different meanings with various functions; and while Macklin's claim mostly refers to the abstract Kantian dignity (i.e. dignity as inherent value), the other senses of dignity have more concrete meanings. The same answer is also given to the problem of the inviolability of dignity: although Kantian dignity is inviolable, this concept has other meanings which are not about an inalienable characteristic of human beings and are therefore subject to violation.

I agree with this position and I believe that what we are finding in some bioethical documents as instances of violability of human dignity, mostly refers to the other non-Kantian meanings of dignity. However, it is also important to classify the senses of human dignity correctly. The way in which some literature addresses this issue has, in my opinion, fallen short of accurately responding to the concerns of dignity opponents.

For instance, Roberto Andorno suggests two different, but complementary, senses of human dignity, after maintaining that Macklin and her critics are talking about different things (2013: 967). The first meaning is dignity as a general principle which has a central place in policy documents. The other sense of dignity, however, refers to the standard of health care and

reflects a concrete and context-specific understanding of the patient as a 'person' (Andorno 2013: 972 - 973):

> While dignity as an overarching principle fulfils a foundational and guiding role of the whole normative framework governing biomedical issues, dignity as a standard for patient care embodies a much more concrete and context-specific vision of the patient as a ''person''. Both approaches, far from being in conflict, are just two different sides of the same coin. They are complementary. The general approach (dignity as a policy principle) is the *objective* component of dignity: it refers to the inherent value that society recognizes in each of us; it is about how *others* see each of us. The concrete approach (dignity as a standard for patient care) relates to the *subjective* component of dignity: it is a consequence of the inherent value that I recognize in myself; it is about how *I see myself*; it results from my awareness of being a 'subject' and not a mere 'object'; it leads me, if I am a patient, to reasonably expect certain attitudes and behaviours from health care professionals (Andorno 2013: 971, emphases in original).

However, this classification of dignity faces several questions and, hence, fails to fully address the relevant concerns. The first question is about the way in which Andorno has distinguished dignity in a general sense from dignity as a standard. The objective side of dignity is familiar: it is close to what has been explained as Kantian dignity, i.e. dignity as inherent value which everybody possesses. The subjective component of dignity, however, is to some extent unclear. On the one hand, being subjective, it is described as a kind of self-awareness of one's own value. Therefore, it depends on how one values oneself and is not related to the recognition of one's value by others.

On the other hand, however, this subjective side of human dignity is also introduced as a standard for patient care. Accordingly, such standards should be self-defined because they are based on the value one finds in oneself - not what others find. But, we should remember that we are talking about the healthcare standards in biomedical documents. Such documents are supposed to be based on a universal understanding of humans' value, rather than a self-defined one. Therefore, the question is how can such a self-defined value be transferred into a universal concept of dignity for use in bioethical documents?

For example, Kant has his own formula for ensuring that what one understands as a motivating rule is a universal categorical imperative: "act according to maxims that can at the same time have as their object themselves as universal laws of nature" (Kant 2012: 49). If the rule can pass this test it would not be a personal rule: it would be a universal moral rule. Accordingly,

it would be justifiable to expect others to undertake their own duty towards such a rule. But, Andorno has not rendered a formula which can justify undertaking duties toward such self-determined expectations. In fact, Andorno could not give such a formula, because otherwise such subjective dignity would become objective dignity.

Furthermore, I doubt that Andorno addresses Macklin's criticism at all. Firstly, dignity as a standard is almost as vague as dignity in the general sense. The only difference is that the former notion of dignity is a contextualised form of the latter, but with no more clarity. But the more important point is that Macklin's criticism is exactly about the role of dignity in the context of bioethics (i.e. what Andorno calls dignity as standard), and not only in the general sense. Therefore, contrary to what Andorno has claimed, both Macklin and Andorno are apparently talking about the same issue.

Moreover, Andorno has also insisted that dignity as a standard of health care reflects an understanding of the patient as a 'person' (2013: 973). However, it seems that once again the same problem that Macklin refers to arises: for Andorno, dignity either has a general sense, which as he stated is naturally vague, or functions as a standard, which is seeing a patient as a 'person'. Therefore, for Andorno, dignity either has a vague sense or is equal to respect for the person. But the 'vagueness' of dignity and the equivalency of 'respect for dignity' with 'respect for the person' are exactly the criticisms of Macklin. Thus, Andorno actually has fallen short of showing that Macklin and her critics are talking about different things[24].

The upshot is that philosophical conceptions of human dignity should be defined in such a way that they be compatible with the manner in which people commonly utilise the notion. In this regard, I think that Doris Schroeder is more successful in identifying the various senses of dignity than Andorno. Schroeder determines, firstly, two concerns about human dignity in bioethics, namely its violability and its vagueness (such as in supporting two opposite sides in the debates concerning euthanasia). Then, Schroeder draws our attention to four different meanings of dignity and suggests that in any debate on dignity, such distinct senses should be considered (2008: 236). In short, the four concepts of dignity are introduced as follows (ibid: 233-235):

- *Kantian Dignity*: in this sense, as explained before, having dignity means to have an inner worth which should be respected by all, and to not be treated as a means.
- *Aristocratic Dignity*: this pre-modern sense of dignity was only attributed to highly

[24] There are some other problems with Andorno's suggestions which I ignore due to the limitations of space.

ranked people. When Kings, popes, and other nobles acted according to their positions, they behaved in a 'dignified' way. Schroeder defines aristocratic dignity as: "the outwardly displayed quality of a human being who acts in accordance with her superior rank and position".

- *Comportment Dignity:* in this form of dignity, we are mostly talking about what people expect to see from a person in a society. This sense can better be understood when it is considered by its absence: "[…] it is undignified to snooze on a train, it could appear undignified to tell a rude joke at an official dinner with one's mouth full, to giggle at an obituary, to kiss one's partner in a Catholic church (unless he is the groom), to spit onto the street, to undress or relieve oneself in public, and so forth." In short, comportment dignity "is the outwardly displayed quality of a human being who acts in accordance with society's expectations of well-mannered demeanor and bearing".
- *Meritorious Dignity:* dignity in this sense is applied to those who have a high level of self-worth, and have "reliable character disposition toward courage, justice, wisdom, and temperance, which are four cardinal virtues according to Aristotle". This sense of dignity is not expected to be seen from everybody, as Aristotle emphasised these as the characteristics of 'ideal' human beings. In this regard, dignity is "a virtue, which subsumes the four cardinal virtues and one's sense of self-worth".

What the above different meanings of dignity suggest is that all non-Kantian meanings are not inalienable (inviolable). They can be gained, lost, or violated. Therefore, when we talk about losing or violating dignity, it is about one of the three non-Kantian classes of dignity. Schroeder has also endeavoured to resolve the problem of ambiguity in the meaning of dignity with the same strategy. After referring to some quotes from advocates and opponents of euthanasia, she maintains that while the Christian authors use the Kantian sense of dignity to show that "the purposeful acceleration of death of an intrinsically valuable being is contrary to this being's intrinsic dignity and must therefore be prevented", the Death with Dignity organisations appeal to meritorious or comportment dignity, in order to explain "[w]hat one might have tried all one's life, to fit into society's standards of decent behavior, one might not be able to achieve in death" (ibid: 236).

Despite, the instrumental attempts of Schroeder in describing the different meanings of human dignity, she does not clarify how these meanings of dignity are related together, and if we can find any connection between the inalienable concept of Kantian dignity, and the violable non-Kantian notions of dignity. I will return to this classification of dignity in a forthcoming section, and will suggest a meaning of dignity as 'decency' as representative of the three non-

Kantian senses of dignity, whilst simultaneously being rooted in the Kantian one[25].

Before finishing this section on Macklin's objection I would like to mention that the notion of autonomy has different senses, too. At the very least the concept of autonomy to which Kant refers is apparently different from Macklin's. For instance, in referring to a bioethical document, Macklin states:

> The first such statute, the California Natural Death Act 1976, began: "In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life–sustaining procedures in the event of a terminal condition." In this context dignity seems to be nothing other than respect for autonomy (Macklin 2003: 1419).

This sample statement reveals that what Macklin mentioned as autonomy in this article refers to the sense of free–selecting. For her, respect for autonomy means respecting the right of people to choose freely. It should be noted that this sense of autonomy (as choosing freely) is different from what Kant describes as autonomy. For Kant a rational agent is autonomous only when she acts in accordance with principles in the form of categorical imperatives (i.e. moral principles). While Macklin's autonomy enhances the freedom of human beings when selecting their way of life, Kantian autonomy seems to put limitations on acting freely by legislating ethical principles for moral agents: the former's autonomy is about freedom, but the latter's is about legislating principles[26].

2.4.2. A Summary of Responses

I would like to briefly review the potential responses given to critics against dignity. It was explained that there are some empirical and analytical reasons for thinking that 'respect for dignity' cannot be equated with 'respect for autonomy' in the biomedical context. Nor is it equal to respect for the person, owing to the fact that 'respect for dignity' indicates a *specific kind* of respect for the person (i.e. seeing her as an end). Furthermore, the notion of respect for the person alone cannot convey all of the important implications of human dignity.

[25] See section 2.5.

[26] In fact, Kant does think that autonomy is freedom – moral freedom, which consists in autonomously willing the moral law – rather than freedom to choose whatever course of action one happens to want.

I also admitted that whilst the concept of dignity in general is vague, this is in fact the story of all key moral notions. In this regard, we first need to bear in mind that dignity should be seen as a basic ethical doctrine or belief, i.e. believing in the valuable status of human beings and the subsequent implications of this. Then, in the light of such a belief, we need to discuss the implications of dignity in specific contexts in order to clarify what dignity specifically implies in each context. There is no doubt that, in some cases, the concept of dignity may indicate different (or even opposite) implications. However, this is not a suitable reason to eliminate the notion entirely given that it can, at the very least, inspire us when we are considering many other issues, e.g. when we are devising global human rights instruments. Also, clarifications of the different meanings of dignity can be helpful in dealing with the 'slippery' aspects of human dignity.

Finally, the explanations about the different senses of dignity given above has shown that while dignity in the Kantian sense is inalienable, in other meanings it is not (i.e. dignity in those senses can be given or purged). Also, I will explain that when we are talking about the violation or loss of dignity we are referring to the condition, behaviour, or opportunity of which one is entitled to enjoy (or benefit from), but of which one is deprived.

2.4.3. Dignity as a Secular Concept

Before finishing this section, I would like to briefly discuss another concern of Macklin's. As quoted earlier, she believes that dignity is a religious concept that 'crept' into secular bioethics. There are two points that I would like to elaborate on with respect to this view. First of all, dignity in its egalitarian sense is a relatively recent concept and we cannot therefore expect to find the same notion in the main religious sources, such as the Jewish and Christian Scriptures. In this regard Sulmasy says the following:

> While it is often assumed that the idea of dignity is essentially religious, it is hard to make this case from the Jewish and Christian Scriptures. The Hebrew word translated as 'dignity', *gedula*, occurs rarely in the Hebrew Scriptures and means something more like nobility of character or personal standing in the community. The Greek σεμνοτης (*semnotes*) is sometimes rendered in English as 'dignity'. It occurs, however, only three times in the Christian Scriptures and is probably better translated as 'seriousness'. The word best translated today as 'dignity', αξιοπρε΄πεια (*aksioprepeia*), is not used in the New Testament at all (2007: 10).

However, it does seem as though the essence of the concept of dignity and its implications has

a strong compatibility with religious thought. Consequently, we can see that this concept has emerged in the more recent stages of Catholic Christianity. For example, the Compendium of the Social Doctrine of the Church says the following:

> *In fact, the roots of human rights are to be found in the dignity that belongs to each human being*. This dignity, inherent in human life and equal in every person, is perceived and understood first of all by reason. The natural foundation of rights appears all the more solid when, in light of the supernatural, it is considered that human dignity, after having been given by God and having been profoundly wounded by sin, was taken on and redeemed by Jesus Christ in his incarnation, death and resurrection (The Catholic Church, 2004: paragraph 153).

However, the various interpretations given to the concept of dignity are not necessarily similar even within the same religion[27]. All in all, the origin of the modern understanding of dignity should not be regarded as coming from religion. On the contrary, it seems that it is religions which are drawn towards the modern concept of dignity because it allows them to develop their own concerns within the dignity framework. In other words, the implications of the concept of dignity (e.g. equality, duties, etc.) can be seen in the original religious texts and therefore religions have welcomed such a modern concept which facilitates the transition of their thoughts.

Moreover, we cannot forget the claims of those such as Schroeder who believes that dignity was an indicator of a person's social standing in pre-modern societies. This historical sense is far from our modern understanding of dignity. Therefore, if the concept of dignity stemmed from religion then since, for example, Christianity started tens of centuries ago, dignity should have a hierarchical sense rather than an egalitarian one.

However, I admit that the concept of dignity in recent decades has been turned into a powerful tool used to impose religious concerns in the context of bioethics. For example, Pinker strongly criticises the report of *The President Council of Bioethics*, in which it was supposed that the report could explain "what dignity is or how it should guide our policies". In addition to criticising the failure of the report in addressing the issue, Pinker also questioned the contributors of the report. Pinker counted 21 authors of 23 who are related to religious institutions (2008: 28). This is an example to show how dignity can be a useful instrument to

[27] See for example, Soulen & Woodhead (2006) on the different interpretations of the concept of dignity in Protestantism.

push religious ideas into bioethics.

Nevertheless, we should not forget that the concept of dignity gives the same power to the opposite side as well. For example, in the case of euthanasia, as explained above, the advocates of physician-assisted suicide appealed to the notion of dignity to enforce their belief in the human right to die peacefully. Thus, dignity is not a concept merely used in service of religious beliefs. The fact is that religious ideas can 'creep' into the secular context of bioethics with or without the concept of human dignity. Human dignity is only one notion that religious adherents can use to convey their beliefs, but it does not mean that they could not do the same if there were no such concept at all. Therefore, even though the notion of dignity is used by religious adherents, it is itself a secular concept.

Nevertheless, the discussions about dignity seem to be endless, and involve different disciplines, beliefs and perspectives. It is difficult to firmly claim that either the opponents or the advocates of dignity are the ultimate winners of this long debate. However, given the explanations above, I am inclined to embrace this concept as a leading notion that can highlight the powerful idea of the valuable status of human beings and all its crucial implications: that all people are equal in such value, that this value endows them with entitlements whilst imposing duties upon them, and that they should always should be treated as an end.

2.5. The Meaning of Nussbaum's Dignity

Thus far, in order to establish a basis for my arguments about Nussbaum's account of human dignity, I have tried to cover the core aspects of the concept of dignity in Kant's perspective. The main areas of this concept included the meaning, the implications, and the theory of human dignity. As Nussbaum has not discussed these important issues related to human dignity in one place, the description of Kantian dignity can help me to introduce Nussbaum's conception of dignity by comparing her viewpoint with that of Kant's.

In this light it is now time to explore Nussbaum's account of human dignity. My explanation of this will be on the basis of the main areas of human dignity which I mentioned in the Kantian section. In this chapter, however, I am going to consider the theoretical aspects of Nussbaum's dignity, namely the 'meaning' and the 'theory' of human dignity. The *implications* of Nussbaum's notion of dignity, considered as the practical aspects of her account, will be investigated in the next chapter, in order that I can begin to present the relevant arguments in the context of the hospital environment.

In this section, I will try to discover the 'meaning' of human dignity in Nussbaum's ideas. This is because Nussbaum has not clearly explained this issue in her writings. I will illustrate that Nussbaum has used the concept of dignity with two distinct, but connected, meanings and that she does not explain (or perhaps notice) the difference between these two conceptions. One of them is similar to the Kantian meaning of dignity, i.e. dignity as the inner value of human beings. The other one, however, concerns a 'decent' quality of human life which befits the valuable status of human beings. I will call it dignity as 'decency'. However, this notion is not detached from common understandings of the notion of dignity. In this regard, and in the following sections, I will show how we can relate the notion of dignity as decency to common-sense notions of dignity.

2.5.1. Killmister's Aspirational Dignity

Despite the problems and deficiencies of Kantian dignity discussed previously[28], it seems he was able to establish an analytical structure in which the common-sense notion of dignity was brought within a systematic framework of moral arguments. Considering the literature published after Kant, it is obvious that his intellectual structuring of the concept of dignity had profound effects on later thoughts concerning the issue. In particular, Kant's ideas concerning the implications of dignity (e.g. the inherent value of human beings, equality, rights and duty) are reflected in many international human rights documents, as well as national legal systems.

Perhaps this is the reason that the universal understanding of dignity, which insists on certain entitlements and provisions (i.e. human rights) based on the equal, inalienable, and intrinsic value of human beings, is renowned as being the Kantian sense of dignity (or Kantian dignity). (In this section I will also refer to this meaning of dignity as Kantian dignity, for the sake of brevity. We may even argue that Nussbaum's *meaning* of dignity is on some occasions equivalent to the Kantian sense, even though Nussbaum's *theory* about dignity is more Aristotelian than Kantian. And of course, it does not mean that there is universal agreement on Kant's arguments about dignity.)

However, the concept of dignity has not lost its other more common meanings; those which are not exactly the same as the Kantian one. Losing dignity, harming or damaging dignity, or even enhancing dignity are phrases that are difficult to explain with reference to only Kant's conception of dignity as inalienable. As mentioned in the previous section[29], Schroeder

[28] See section 2.3.

[29] See section 2.4.1.2.

recognises four distinct conceptions of human dignity. I think she successfully identifies different meanings of dignity with both common and theoretical senses. (Of course, I do not claim that dignity has only these four senses. However, I think, these conceptions can cover the main contemporary meanings of dignity). In contrast with Kantian dignity, the other three meanings of dignity have not been given an analytical (philosophical) description but instead convey common understandings of dignity.

However, this does not mean that there is no logical link between them. One of the deficiencies in Schroeder's work is that she could not connect the three non-Kantian conceptions of dignity together (Killmister 2010: 164), nor could she find the root of Kantian dignity in the other common concepts of dignity. In other words, it is not clear what the central elements are in the three non-Kantian notions of dignity that cause people to use this concept (i.e. dignity) for all of those meanings. Likewise, whether or not there is any connection between the common meanings of dignity and the analytical Kantian meaning has not been clarified.

The three non-Kantian senses of dignity seem to be disconnected *social* terms, rather than *moral* senses which are interconnected. If we can suggest a single notion which on one hand can represent the three non-Kantian types of dignity, and on the other hand is interwoven with Kantian dignity, then we may be able to turn those social understandings of non-Kantian dignity into a single moral sense. Such a notion, then, can assist us in resolving the confusion concerning the different meanings of dignity in the context of bioethics and its documents.

In this light, I will argue in this section that the sense of dignity as 'decency' is representative of the three non-Kantian senses (I need to clarify, here, that the term of 'decency' should only be seen as a *label*, and I do not consider any independent content for this term to be given to the notion of dignity). I will elaborate this meaning of dignity and I will explain why considering dignity as decency in Nussbaum's Capabilities Approach can assist us in understanding her thoughts. Before this, I will first critique Suzy Killmister's suggestion of 'aspirational dignity' as an alternative to common meanings of dignity. Then, I will analyse the three non-Kantian types of dignity in order to find the common elements between these conceptions and their relation to the notion of a decent life. After introducing dignity as decency, I will endeavour to demonstrate how the suggested concept of dignity as decency can be considered as a moral sense of dignity.

Killmister (2010) has proposed 'aspirational dignity' as a concept which can stand in the place of the three non-Kantian ones. However, scrutinising her analysis of the non-Kantian meanings of dignity reveals some problems with her suggestion. Killmister, in her *Dignity: Not Such a Useless Concept*, which actually targets Macklin's objection, first re-introduces

the definitions of the four meanings of dignity given by Schroeder (Killmister 2010: 160 – 161) (I think it is worth briefly doing the same here):

- Kantian Dignity: as defined previously, is the universalist concept which has inspired various international human rights instruments. It is about the inherent, equal, and inalienable value of human beings which entitle them to certain conditions and opportunities. It is worth noting again that I am going to use the same notion of 'Kantian dignity', which means I am referring to the Kantian *meaning* of dignity, and not to his *theory*.
- Aristocratic Dignity: is the pre-modern conception of dignity in which to be a dignified highly ranked person (i.e. dignitaries) meant to act in accordance with the demands of one's position.
- Comportment Dignity: is to behave in a way consistent with social norms and expectations. This kind of dignity can be better understood in the adverse sense – e.g. there would be a lack of comportment dignity if one "threw food at one's companion in a restaurant."
- Meritorious Dignity: inspired by Aristotle, this kind of dignity presents having virtue, particularly the cardinal ones including self-respect, temperance, justice, courage, and wisdom – e.g. "Nelson Mandela […] displayed meritorious dignity throughout his imprisonment on Robben Island."

Killmister devalues aristocratic dignity in her classification because "aristocratic dignity has little relevance in the modern world, and even less in medical ethics" (2010: 161). She then collapses the comportment and meritorious dignity into one meaning of dignity; 'aspirational dignity'. For this purpose, Killmister needs to connect these two kinds of dignity (i.e. comportment and meritorious dignity). Hence, she states:

> The two concepts of comportment and meritorious dignity can be brought into alliance through seeing comportment dignity less as an upholding of external standards and norms, and more as the upholding of one's own standards and norms. This understanding of comportment dignity is more closely in line with how the term is utilised in the discourse of medical ethics – for example, when advocates of euthanasia argue that one should be entitled to die with dignity, or when patients in overcrowded wards complain that their dignity is being violated. It is not merely an inability to conform to social norms that may be experienced in situations of medical dependency, but also an inability to realise one's values of, perhaps, self-reliance, grace, courage, or even basic personal hygiene. Situations that constrain the individual to act in ways they find abhorrent or demeaning will undermine that individual's ability to live

according to their own standards (Killmister 2010: 161).

Accordingly, "aspirational dignity is the quality held by individuals who are living in accordance with their principles" (Killmister 2010: 161). Consequently, she determines two senses of dignity: Kantian and aspirational. Yet, she does not stop at this point and goes on to unite these two by defining dignity as a capacity:

> In order to understand dignity as both inalienable and aspirational – a move that must be made if dignity is going to provide guidelines for ethical action towards patients – it is necessary to see it as a capacity. Understood in this way, dignity's inalienability comes from the fact that the potential for principled action grounds at least in part the moral worth of all persons. This keeps it well within the realm of the Kantian concept […] Dignity's aspirational sense, however, now comes from the fact that the realisation of these principles can indeed be thwarted […] As the realisation of dignity can be lost or denied, medical practitioners have reason to be attentive to the potential for their actions to undermine the standards and principles of their patients, and in particular the potential for their actions to cause humiliation (Killmister 2010: 162).

In this regard, she defines dignity as "the inherent capacity for upholding one's principles" (Killmister 2010: 162). I admire her attempt to identify a sort of dignity other than Kantian dignity in order to address some of the criticisms directed at the concept of human dignity. Nonetheless, I think her focus on the objections to dignity distracts her from the task of ensuring that all of the implications of dignity in her single definition cohere. Nor is the way she defines aspirational dignity effective in dealing with theoretical challenges.

Firstly, it seems that Killmister has lost the central meaning of comportment dignity (i.e. social norms and expectations) in her attempt at linking this meaning of dignity with the meritorious one. Schroeder's discussions concerning comportment dignity are mostly focused on showing that those who do not follow social norms and expectations lack dignity. However, Killmister strangely interprets this as abiding by one's own standard. Giving some examples, she strives to illustrate that what is socially expected can also be considered as personal expectations.

Presumably, in this way, Killmister wants to bring the notion of comportment dignity to a meaning closer to that of Kantian dignity (nearer to notions such as autonomy, etc.). I do not think that defining a meaning of dignity in this way is problematic in general, but this new sense of dignity would not be an interpretation of *Schroeder's comportment dignity* anymore; it is a new conception of dignity. The problem is that Killmister's departing from Schroeder's comportment dignity is incompatible with her main goal, i.e. the unification of *Schroeder's* four conceptions of *dignity.* Of course, it is not necessary for Killmister to accept whatever

Schroeder states. However, if she wants to define new meanings of human dignity then this would be another project. She needs to show that her suggested meanings of human dignity are still common-sense meanings, in a similar vein to Schroeder. And again, obviously such new notions of dignity would not be Schroeder's notions of dignity.

The reason that I think this way of interpreting comportment dignity cannot convey the same meaning as Schroeder's terms is that one may define one's personal standards beneath or beyond social norms and expectations. We can think of numerous instances in which one's personal standard is not in line with social norms. For example, a patient cannot shout at a nurse for fun, even if it is acceptable in her standards to frighten others in order to relieve her own stress. Thus, what Schroeder defines as comportment dignity is not what Killmister interprets it as. However, one may defend Killmister's position by pointing out that meritorious and comportment dignity are collapsed together, and that by virtue of meritorious dignity one would not shout at a nurse, for instance. Although a virtuous person might avoid being beneath the thresholds of social norms, she still may define a level of standard much beyond the social norms. As we shall now see, this can cause another problem.

It is hard to match the 'duties and rights' implications of the notion of dignity with such self-defined standards. This is because it is unclear to what extent people have to undertake duties towards the personal standards of others. In other words, it is unclear why other people should accept responsibilities in providing for the standards which are determined by an individual, when they may be beyond the accepted social standards. Killmister answers this question by claiming that "to be denied the ability to uphold one's personal standards is experienced as humiliation, with deep consequences for one's self-respect" (Killmister 2010: 163). Hence, we should comply with the standards of others. However, I do not think that one can 'ethically' oblige others based on one's personal definition of humiliation.

For example, it seems to be acceptable that if one defines a high level of standards for oneself, according to which one does not allow oneself to attend casual (but still polite) parties, in order to avoid feeling humiliated, that one therefore only attends very formal parties. It is not acceptable, though, that one feels others have a duty to not have casual parties. Hence, such a feeling of humiliation cannot imply a right for the dignity-bearer. In short, if one defines a high level of value and standards for oneself we cannot define everyone else's duties and rights accordingly.

The next point is that the way in which Killmister utilises the concept of 'capacity' is ambiguous. Killmister claims that dignity as a capacity can cover both the Kantian and Aspirational senses of dignity. Therefore, dignity as "an inherent capacity for upholding one's

principles" should involve the Kantian sense of dignity – i.e. inherent value. However, Killmister has not clarified how the sense of worthiness is included in her notion of dignity as a capacity.

In order to incorporate the sense of 'value' into dignity as a capacity, I can imagine modifying Killmister's dignity in this way: an individual has value in virtue of having the capacity for 'upholding one's principles'. However, this definition of dignity would then be almost identical to Kantian dignity, in which one has value in virtue of one's capacity for rationality (i.e. legislating principles). But now the problem identified in Kantian *theory* will arise in Killmister's account of the *meaning* of dignity – namely, grounding dignity solely in the capacity to legislate principles. In this regard, we can say that not only does Killmister's suggestion of dignity as a capacity add nothing to the Kantian notion of dignity, but it also exacerbates the problem in the discourse of dignity because she has brought a problem with the Kantian theory dignity into the matter of the meaning of dignity.

The main issue with Killmister's suggestion is that the same form of problem faced by Kant arises, i.e. the problem of marginal cases. Killmister has to explain how people with a temporary or permanent disability in legislating their own principles (e.g. children, the severely mental ill, comatose patients) can belong in the group of dignity-bearers. Killmister gives two attempts at replying this criticism (Killmister 2010: 163 – 164), however, neither is satisfactory, in my opinion. In the first attempt, Killmister admits that according to this definition some people may be excluded from the list of dignity-bearers. However, she believes that this does not mean that other principles (she mentions, for example, "susceptibility to pain, or a general ethic of care") cannot play their role in bioethics. However, this reply is in contrast with the sense of dignity in the international human rights documents in which dignity is possessed by *everybody*. This is a problem because she claims that her definition of dignity as a capacity can cover all senses of dignity in bioethics.

Killmister also argues that if we consider the dignity of other parties (e.g. doctors and nurses), we can see that the concept of dignity can still function: medical staff can provide for the ethical needs of their patients for the sake of their own dignity, i.e. in order to respect their own dignity they respect the dignity of their patients. However, this point cannot resolve the problem as it still does not attribute dignity to all patients. Moreover, if we believe that some people do not have valuable status, there is no reason to respect them. In this regard, the dignity of medical staff would lose its function too. Consequently, Killmister's first attempt at a reply could not properly respond to the relevant criticism and the same problem exists with her second attempt as well.

In the second attempt, Killmister tries to incorporate many of the previously excluded people (of her first attempt) by suggesting that dignity should be considered "beyond the timeframe in which we are cognisant of those standards and principles. In other words, I have an ongoing interest in whether I am humiliated, even if I am asleep, comatose – or even dead – and will thus never subjectively experience the shame" (Killmister 2010: 163). Even though in this suggestion she shortens the list of human beings with no dignity (by including children, comatose patients, and the like), there are still some groups of people which are excluded from the list of dignity-bearers (e.g. people who are severely mental ill permanently). Therefore, my criticism remains. All in all, the way Killmister attempts to reconcile the four conceptions of dignity into one notion is unsuccessful.

2.5.2. Modifying Comportment Dignity

Above I critiqued Killmister's attempt at connecting the different meanings of dignity. In the following passages, I would like to elaborate my suggestion for the second sense of dignity which I call dignity as 'decency'. For this purpose, in a similar way to Killmister, I will get an advantage from using Schroeder's work in which she introduces her four conceptions of dignity. I will then amend the definitions of those notions. Subsequently, I will show that the central idea which is common among all three non-Kantian types of dignity is the idea of being (or living) *decently*; and hence I label it dignity as 'decency'.

The next step is to articulate how the concept of dignity as decency can be brought into an ethical discourse, by linking it to the ethical notion of Kantian dignity. And finally, I will illustrate that the concept of dignity used in Nussbaum's literature is very near to the sense of dignity as decency. Before beginning the arguments in this section it is necessary to consider an important issue about dignity. As was explained in the section on Kantian dignity[30], dignity implies certain *rights* of dignity-bearers as well as *duties* of moral agents towards dignity-bearers. In this regard, in considering the dignity of one person we have two sides: rights (entitlements) and duties (responsibilities). For example, we can understand the following sentence differently depending on which of the two sides we focus on: 'dignity demands decent behaviour'. From the duty-side, the concern is to see decent behaviour *from* the dignity-bearer. But, from the rights-side, the concern is to see decent behaviour *towards* the dignity-bearer.

Given this explanation, I think we need to amend the way comportment dignity is described

[30] See section 2.3.2.1.

by Schroeder. She defined comportment dignity as the "outwardly displayed quality of a human being who acts in accordance with society's expectations of well-mannered demeanor and bearing" (2008: 234). This definition and the explanations about comportment dignity given by Schroeder illustrate that she formed the definition of comportment dignity from a duty-viewpoint. Dignity presents the quality of being a dignity-bearer through one's behaviour. I think we need to expand this notion, and include a rights-viewpoint understanding of comportment dignity as well.

From the rights-view of dignity, we should also worry how others behave towards the dignity-bearer. For instance, if a patient complains that her doctor treats her with little dignity, the concern is the ignorance of the 'entitlements' of the dignity-bearer (i.e. the patient), and not her 'responsibilities'. Thus, Schroeder's comportment dignity needs to be modified by adding a rights-view to this sense. I would also like to make a change in the concept of 'society's expectations' in a way that is more compatible with the elements of dignity in a moral sense. In comportment dignity, what shows that a dignity is harmed (or violated) is society's expectations and norms: if a person behaves in a way evaluated as indecent according to the society's norms, the act would be judged as being beneath the dignity of the agent. Therefore, society's expectations and norms shows the standards (or levels) which determine what is expected as the *responsibility* of the dignity-bearer towards others. Dignity, in this sense, is about the responsibility one should undertake to behave decently and treat others well.

It was explained that Schroeder's comportment dignity operates under merely the duty-view. However, with the inclusion of the rights-view in this conception of dignity, we will now need to consider the entitlements of the dignity-bearer as well, i.e. the ways in which social expectations might determine how a dignity-bearer should be treated by others. Society's norms and expectations, from this point of view, determine the *entitlements* of the dignity-bearer, rather than her responsibilities. For instance, society does not expect that a comatose patient be left semi-naked in a public corridor in a hospital, because it harms her (comportment) dignity, i.e. it is a violation of her entitlement to being in a private environment. All in all, by expanding comportment dignity by including both the rights and duty viewpoints, we can benefit from the notion of the 'responsibilities and entitlements' of dignity-bearers, instead of the 'norms and expectations' of a society[31].

It is also worth noting that my claim is not that these examples only involve comportment

[31] I admit that these 'responsibilities and entitlements', for now, are related to social norms, and not to moral principles. But through the next passages I will attempt to give a moral interpretation of these concepts.

dignity. What I am doing is modifying the notion of comportment dignity in such a way so as to connect it to other meanings of dignity, in order to identify a single meaning of dignity as representative of all the non-Kantian meanings. Therefore, it should not be viewed as a problem if some instances of the modified form of comportment dignity are the same as instances of other meanings of dignity. This is because the instances of all these meanings of dignity are going to be interpreted as instances of dignity as decency. However, whilst undertaking such a modification, unlike Killmister, I am trying to remain faithful to the essence of comportment dignity as defined by Schroeder.

The last amendment I would suggest in terms of comportment dignity is to consider the matter of not only behaviour, but also conditions, opportunities, and facilities. From the rights-viewpoint the dignity of a person does not only imply her entitlement to be treated with dignified conduct by others; it also indicates that the person is entitled to being in an appropriate condition and to have access to a suitable level of facilities and opportunities[32]. In terms of patients, for instance, it is not only important that they be treated respectfully, but they are also entitled to be cured in a decent environment with sufficient facilities and proper process of treatment and conduct. That is why a patient who is hospitalised in an overcrowded ward may perceive her situation as a violation of her dignity.

Briefly, I believe that the violation of comportment dignity is not merely limited to the 'well-mannered demeanor and bearing' of a moral agent which is settled based on a society's expectations and norms. It needs to be amended in the ways in which I identified:

- I included a rights-view to comportment dignity such that it is not only about how a dignity-bearer is expected to behave, but it is also about the issues surrounding what one is *entitled* to, according to society's expectations and norms.
- I divided social norms and expectations into one's 'responsibilities' (in a duty-view) and 'entitlements' (in a rights-view) concerning what socially decent for a person.
- I added some other aspects of comportment dignity to the single issue of behaviour, which included decent opportunities, and facilities, as well.

I think the notion of a 'decent life' (for which I named the second meaning of dignity as

[32] From a duty-view, when we call behaviour "decent" it is obviously about what is expected to be seen from a moral agent. However, when we are talking about decent conditions, opportunities and facilities from a duty-viewpoint, it is about the expected responsibility of the agent in providing for the conditions, opportunities, and facilities to which others are entitled.

'decency'[33]) can address all of the aforementioned elements of comportment dignity from both the rights and duty points of view. In answering, 'what is decent for a person?', one may produce a list of ways of behaving that an agent has a responsibility to abide by, on the one hand. On the other hand, one may also list certain entitlements of a dignity-bearer that she can expect from others – namely decent behaviour, opportunities, and facilities for the dignity-bearer. Therefore, the view of dignity that I am calling the "decency view" can gather together all of these elements of comportment dignity under its umbrella. As we shall now see, the same line of argument can be applied to the notion of aristocratic dignity as well.

2.5.3. The Spirit of Aristocratic Dignity

In contrast with Schroeder, who overlooked aristocratic dignity, I think we should weigh up this pre-modern concept of dignity. This is because the notion of dignity was not invented in the modern era and therefore our current understanding of dignity should be profoundly linked to its historical origins. To find the central elements of modern dignity we should consider how the concept was understood in the past and then try to discover how it has been developed or modified into its modern meaning(s). In his book *Dignity, Rank, and Rights,* Jeremy Waldron uses just this strategy to find the exact meaning of the concept of dignity:

> [...] my own view of dignity is that we should contrive to keep faith somehow with its ancient connection to noble rank or high office (Waldron 2012: 30).

Waldron holds that the historical concept of dignity was about the status of the noble. He points out that the structure of many societies in the past was hierarchical; people were evaluated based on their social status. This sense of dignity (i.e. aristocratic dignity in Schroeder's terms), then, is 'transvalued' into the contemporary understanding of dignity:

> [...] I believe that as far as dignity is concerned the connotation of ranking status remained, and that what happened was that it was transvalued rather than superseded (Waldron 2012: 31).

Waldron, then, attempts to show that the hierarchical concept of dignity is transvalued into an egalitarian sense. Therefore, our conception of dignity in the modern era remains related to

[33] Again, I would like to emphasise that the term of 'decency' which I use in this meaning of dignity functions only as a label – i.e. only as short form for the notion of a 'decent life'. Therefore, it does not mean that the second meaning of dignity is the same as the *concept* of decency; it is rather the same as the concept of a 'decent life'.

the rank status of human beings but has now developed to include a sense of equality:

> So that is my hypothesis: the modern notion of *human* dignity involves an upwards equalization of rank, so that we now try to accord to every human being something of the dignity, rank, and expectation of respect that was formerly accorded to nobility (Waldron 2012: 33, emphasis in original).

I am inclined to go along with Waldron in that the modern meaning of dignity cannot be completely detached from its historical meaning. His main concern, though, is to show how the hierarchical meaning of dignity can be changed into an egalitarian one:

> Every man a duke, every woman a queen, everyone entitled to the sort of deference and consideration, everyone's person and body sacrosanct, in the way that nobles were entitled to deference or in the way that an assault upon the body or the person of a king was regarded as a sacrilege (Waldron 2012: 34).

However, as Schroeder indicates, modern dignity does not have a single meaning; there are two understandings of the concept (i.e. comportment and meritorious dignity), other than the inalienable egalitarian dignity (i.e. Kantian dignity). In this regard, if we combine Waldron's idea (i.e. of dignity as a 'transvalued' notion of aristocratic dignity) and Schroeder's (i.e. we have three contemporary meanings of dignity[34]), then we should be able to find some connections in the essence of aristocratic, comportment, and meritorious dignity. I believe that the central elements in aristocratic and meritorious dignity are similar to that of comportment dignity; they concern the notion of what is decent for a person in terms of one's responsibilities and entitlements.

To show this in aristocratic dignity let us imagine a ranked society which has two sides: on the one side there are the elites such as the kings, queens, dukes, duchesses, knights, scholars and the like. Only people with a high social status (which may be called elites, dignitaries, hierarchies, etc.) are dignity-bearers. On the other side, there are 'the ordinary people', those considered to be of lower social status such as labourers, butchers, carpenters, farmers and the like. In contrast to the elites, these people do not have dignity.

In such societies, we can see that both the duty and rights viewpoints concerning social expectations and norms (i.e. responsibilities and entitlements) function in a similar way to their roles with respect to comportment dignity: low ranked people (i.e. those who were not

[34] Among her four suggested concepts of dignity Schroeder believes that the aristocratic sense is an entirely pre-modern notion, and that only the other three are currently being used.

dignity-bearers) had *responsibilities* to behave or act in a decent way, and provide decent opportunities and facilities for the nobles (who had rights as dignity-bearers). For example, they were expected to sacrifice themselves in order to save the lives of dignitaries in wars; bow down in front of the king; they had to provide for the luxurious lives of the elite even if it reduced them to impoverishment, and undertake many other responsibilities. Of course, these duties varied between different cultures and traditions, but the common point was that ordinary people were expected to undertake their responsibilities for the sake of what was seen as decent for the dignity-bearers.

From the rights-view then, corresponding to the responsibilities of ordinary people, the elite expected to benefit from certain *entitlements*. For instance, if it was expected that ordinary people were to sacrifice themselves to save the life of the king. Responding to the entitlements of dignitaries, i.e. respecting them, could be seen as behaving in a decent way (e.g. kneeling in front of them), acting in a decent way (e.g. defending the king when at war), or providing for decent opportunities (e.g. education), and decent facilities (e.g. a palace). The elites were even entitled to a decent condition when they were in the hands of their enemies:

> In ages past, chivalry might require that noble warriors, such as knights, be treated with dignity when they fell into the hands of hostile powers; but this was hardly expected in the treatment of the common soldier; they were abused and probably slaughtered (Waldron 2012: 35).

If we consider the pre-modern meaning of dignity, we can provide the same kind of analysis as was offered for comportment dignity; that is, we can interpret societal expectations and norms as 'responsibilities' towards what is decent for dignity-bearers. This meant that, parallel to the responsibilities of the ordinary people, the elites had to behave and act in a decent way which was suitable for their high social status. Dignitaries had to behave in a way that befitted their status, which meant that even simple regular activities such as walking, eating and the like had to follow a distinctive style. The famous novel by Mark Twain (1871 – 1910), the Prince and the Pauper, is an example of the expected differences in behaviour between two classes of people of different status. For instance, the author uses the concept of dignity to show the Prince's expected behaviour and conduct in this sentence:

> The boy stood unconfused in the midst of all those surprised and questioning eyes, and answered with princely dignity – "I am Edward, King of England" (Twain 2001: 215).

All in all, aristocratic dignity is similar to comportment dignity in that the essence of both of these two senses of dignity can be described as what is 'decent' for dignity-bearers which is

reflected in their responsibilities and entitlements. This point is noteworthy in that these responsibilities and entitlements were defined within a social framework, rather than a moral one. Perhaps, this is the reason why Waldron believes that law is the natural habitat of dignity (Waldron 2012: 13), and if this is the case then it is the moral sphere which has more to learn from the law than vice versa (Waldron 2012: 14).

2.5.4. Self-Determined Meritorious Dignity

In terms of meritorious dignity, I do not intend to offer an analysis of this concept. This is because I think meritorious dignity is a kind of self-determined sense of dignity, in which one considers one's own status as highly valuable and behaves and conducts oneself accordingly. However, this does not mean that this understanding of dignity does not fit into the concept of a decent life and its relation to responsibilities and entitlements. The display of this kind of dignity mostly emerges from a duty-view, as the dignity-bearer feels a responsibility to decently present her self-worth and virtues.

Although meritorious dignity usually makes the most sense from a duty-view, it can also be fit into a rights-view as well. For example, a dignity-bearer may consider herself to have a very high level status and accordingly expect a high level of responsibility from others. She may feel humiliated by the behaviour of others even though others do not normally consider such actions as a kind of degrading behaviour. In fact, what is decent for her involves a higher level of behaviour, actions, opportunities, and facilities than others. Of course, as discussed before, it is not clear to what extent others have an *ethical* duty to provide for such self-determined expectations, unless we draw a threshold of entitlements as the minimum level required for a decent life for everyone (the approach taken by Nussbaum). Nevertheless, the point that I want to consider here is that the central elements of meritorious dignity, in these respects, are in line with those of aristocratic dignity – i.e. dignity is about a decent life which can be explained through a responsibility-entitlement discourse.

2.5.5. Dignity as Decency

To summarise the above analysis of the four meanings of dignity: all non-Kantian meanings of dignity are fundamentally alike, in that we can interpret them as a description of what is 'decent for human beings' by referring to a set of responsibilities and entitlements. From a rights-view, a decent life implies a list of entitlements. From a duty-view, in the same way,

the decent life implies what is to be expected from a dignity-bearer with regards to her responsibility to enact decent and dignified conduct. Therefore, we can say that the concept of dignity in its common meanings (i.e. non-Kantian senses of dignity) is about the decent life (from now on, I will call it decency): an answer to the question of *what is decent for an individual?* Taking everything into account, I suggest a sense of dignity as *'decency'* as the additional meaning to dignity as valuable status. This meaning of dignity can not only address the concerns of Schroeder and Killmister, but is also free from the problems and deficiencies revealed in their analysis.

One of the attempts of Schroeder was to show that dignity has some meanings other than the inalienable concept of Kantian dignity, in which those senses are violable. Therefore, when we talk about violation, losing, or damaging dignity we are talking about those other meanings of dignity. Dignity as decency, in contrast with the Kantian sense of dignity[35], is not an inalienable characteristic of human beings either; in the sense that people may not be in a situation that is decent for them. For example, when it said that a doctor violates the dignity of a patient, or an overcrowded environment of a hospital damages the dignity of the patients within it, this refers to an indecent condition or action towards the the patient. Thus, dignity as decency can address the concern of Schroeder and her followers that dignity has a violable meaning.

Moreover, the central feature of dignity as decency is its relation to the concepts of 'responsibilities' and 'entitlements' which therefore avoids Killmister's failure. As explained before, one of the problems of 'aspirational dignity' in Killmister's sense is its relation to the autonomy and the ability of one in determining standards for oneself. Killmister cannot give a clear definition of dignity for the people who lack rationality and, hence, she states that dignity has no content for such people. In contrast, in my suggestion of dignity as decency there is no such deficiency; dignity as decency is applicable to *all* human beings. As this sense of dignity is linked to the responsibilities and entitlements of human beings, instead of autonomy, we still can apply dignity for non-autonomous human beings as well.

Therefore, I believe that the concept of dignity as decency can be considered as the secondary sense of dignity, with which we do not face the problems confronting Schroeder and Killmister. However, this concept of dignity is still about a society's expectations and norms, rather than being a moral notion. Making a bridge between dignity as decency and Kantian dignity can help us to develop a moral understanding of dignity as decency; a concept that I

[35] Kant does use the term 'decency'. However, I am using it in a different way, although the notion of minimum standards will play an essential role in my position.

think is central in Nussbaum's notion of dignity. In the following passages, I will argue for just such a connection between these two meanings of dignity.

2.5.6. Moralising Dignity as Decency

As mentioned before, Waldron thinks that the current concept of dignity is a transvalued form of pre-modern dignity. Also it is said that the analysis of the non-Kantian meanings of dignity indicates that dignity was more related to social norms and expectations, rather than explicitly moral principles. Indeed, Kant was an artist in bringing a pre-modern unequal and social sense of dignity into an egalitarian moral framework with valuable definitions and implications. In particular, 'duty and rights' are two principal elements of Kantian dignity which impact many human rights documents; a meaning of dignity that signifies everybody has equal, inalienable, and inherent worth; a worth which demands respect and endows entitlements.

But, entitlements (rights) and responsibilities (duties), are essential elements in the concept of dignity as decency, as well. This similarity suggests the possibility of turning dignity as decency into a moral concept in which decency represents specific implications of Kantian dignity, namely duty and rights. As was mentioned before, dignity as decency has to do with asking what is decent for human beings, in the form entitlements and responsibilities. If the meaning of what is decent for a human being is interpreted as those entitlements and responsibilities which can be understood through the notion of dignity as value (i.e. those which are known as human rights), then we will have a moral sense of dignity as decency.

In other words, dignity as decency tells us that there are a set of responsibilities and entitlements, properly responding to which brings a decent condition and life for dignity-bearers. If these responsibilities and entitlements are those we understand from Kantian dignity, then we are defining the decent condition within the Kantian moral sense of dignity. In fact, the moralised meaning of dignity as decency focuses on a specific implication of Kantian dignity, namely human rights and the corresponding responsibilities towards such rights.

In this regard, we may interpret the human rights explained in international instruments as an endeavour to depict the minimum requirements for a decent life for human beings. As the human rights documents are based on a moral meaning of Kantian dignity (i.e. seeing human beings as the possessors of valuable status), what we now introduce as the moral meaning of dignity as decency would be within a moral framework. In fact, the moralised meaning of dignity as decency is derived from (or subsidiary to) the meaning of dignity as value (i.e.

Kantian dignity).

To introduce the concept of dignity as decency, it is suitable to see how this notion deals with the main characteristics of Kantian dignity:

- *Human valuable status:* what makes human beings entitled to have a decent life is their valuable status: they are entitled beings because they possess valuable status. For their valuable status, human beings deserve to live in a decent condition. In this regard, the concept of dignity as decency is a *derivative* sense of Kantian dignity.
  People consider human beings' value and check if their condition is compatible with their value – i.e. if it is decent for them. Accordingly, when people cannot enjoy their entitlements (derived from the Kantian sense of dignity), they may say their dignity (as decency) is violated, ignored, or damaged. Therefore, considering the valuable status of human beings is a key notion in understanding and discussing the decent condition of human beings.
- *Equality:* If dignity as decency is considered as a notion which is derived from the egalitarian dignity of Kant, it can convey a sense of equality. As was mentioned above: the decent condition of human beings is defined based on a belief in the valuable status of human beings. Since all human beings are equal in their value in Kantian dignity, what is decent for *human* beings is equal among them.
  This can be considered as the departure point for dignity as decency in the moral sense as compared with its non-moral meaning. Without moralising dignity as decency it does not necessarily imply equality, as what is decent for an individual as a 'member of a society' can be defined by different levels in a social hierarchy. But, when we bring it into a moral system which is based on the equality in human value, then it is about what is decent for *all human beings*.
- *Respect (providing for rights and treating people as ends):* owing to the valuable status of human beings (i.e. Kantian dignity), dignity-bearers have a right to be provided their entitlements. This right is the core meaning in dignity as decency, too. Hence, if a patient, for instance, is treated in a public corridor, then what is decent for her has not been provided, and consequently she may claim that her dignity has been violated.
  Respect, as 'treating people as ends in themselves' can indirectly make sense with respect to dignity as decency as well. This command (i.e. seeing people as ends) suggests that merely providing for the entitlements of dignity-bearers is not sufficient for respecting them. It is also important that such provisions are not offered exclusively for the purpose of utilising human beings. For example, the hospital

environment may be designed suitably in many respects, yet not necessarily in order to respect the dignity of the patients within it. It might instead be designed with the aim of increasing the revenue of the hospital by seeing patients as customers and sources of income.

The moral sense of dignity as decency can also support this idea of respect as it is derived from Kantian dignity: the idea of decency is based on human value which demands treating people as ends. In general, a decent condition for human beings is not merely the condition in which all of the basic rights of human beings have been responded to properly: it is also essential that human beings be included in the ends of those provisions and conducts. (This point can also be explained by stating that one of the conditions of a decent life is to be treated not merely as a means, but also as an end.)

- *Being intrinsic:* the valuable status of human beings is an intrinsic characteristic of human beings. Since with dignity as decency we are talking about the conditions and quality of life of human beings, it is related to something inherent in human beings. Nevertheless, it should be noted that the entitlements of human beings are inherent rights, whether they are provided for or not. For example, education is an inherent right of human beings, but some people may not have access to its decent provision.
- *Inalienability:* in this characteristic, the decency sense of dignity is not similar to the Kantian one, because individuals may lose their decent conditions. Being in an indecent condition, or being treated in an indecent way, is interpreted as violating (or losing, damaging, etc.) dignity; terms which cannot be used for an inalienable characteristic. Actually, the main claim in this section is that we have two meanings of dignity; Kantian dignity, which is inalienable and based on the inherent valuable status of human beings, and dignity as decency, which is violable and based on what is decent for an individual (i.e. what she is entitled to).

All in all, in moral discourse we can utilise two distinct but profoundly connected accounts of dignity. The first is Kantian dignity in which concerns are centred on the inherent and *inalienable* (inviolable) valuable status of human beings. The second concept is dignity as decency which (specifically) emphasises the entitlements of human beings (derived from Kantian dignity) which reflects the decent conditions for an individual. Hence, dignity as decency is a matter of the quality of life; something which can be gained (benefited from) or lost (or violated). Both meanings of dignity are credible: the Kantian dignity is theoretical and reflects the intellectual foundation of human rights and entitlements. Dignity as decency is more derivative and practical (as it is talking about human rights and entitlements). Consequently, it would be acceptable to utilise both senses of dignity in a moral discussion.

However, it is vital to figure out which meaning of dignity is concerned in each case, so as to avoid a misunderstanding of the arguments.

2.5.7. The Meaning of Dignity for Nussbaum

Nussbaum does not signal the recognition of these distinct meanings of dignity. However, she does apparently employ both meanings of dignity as decency and valuable status. While in some cases she talks about an inalienable meaning of dignity which refers to the notion of value and worthiness, in other cases the concept of dignity she uses is not compatible with the sense of value, nor is it about inalienability, but rather it is nearer to the sense I have called dignity as decency. As Nussbaum does not address these different meanings of dignity, reading her works without considering this differentiation may cause confusion. Nevertheless, considering the above explanations of the two different meanings of dignity I believe we can better understand her capability theory.

In several places Nussbaum uses dignity with a meaning which is close to the Kantian conception, namely value and worthiness. For example, Nussbaum states that the function of the concept of dignity in her theory is the same as is used in human rights documents. This is while many, such as Killmister and Schroeder, believe that it is Kantian dignity which has the most influence on the human rights instruments. Elsewhere, she links dignity to the inviolability of persons, and states that these are the core ideas of the Capabilities Approach (Nussbaum, 2006: 80). As mentioned before, where we are talking about the inviolability of dignity it is a sign of the Kantian meaning of dignity.

The following quotation from *Frontiers of Justice* can be considered as another example of using the concept of dignity in its Kantian sense, in which Nussbaum tries to illustrate the distinction between Kantian and Aristotelian dignity. This is a valuable example, in which we can see that Nussbaum uses the Kantian *meaning* of dignity and yet refuses to accept the Kantian *theory (source)* of dignity. (In this paragraph the concept of dignity is clearly used as a synonym of 'value'):

> In chapter 3 much was made of the fact that the capabilities approach uses a political concept of the person that is different from that used in Kantian contractarian approaches. This Aristotelian conception situates human morality and rationality firmly within human animality, and insists that human animality itself has dignity. There is dignity in human neediness, in the human temporal history of birth, growth, and decline, and in relations of interdependency and asymmetrical dependency, as

well as in (relatively) independent activity […] (Nussbaum 2006: 356).

Nonetheless, in the majority of her work, the concept of dignity Nussbaum uses is close to the 'decency' meaning of dignity. In many places she talks about the violation of human dignity (e.g. see Nussbaum 2006: 274, 277, 280, 348). Moreover, Nussbaum talks about the notion of dignity with phrases such as "life worthy of human dignity", "a life with human dignity", "a life compatible with human dignity", and the like. The notion of dignity in these cases is in the service of describing a 'decent' quality of life that she expects for all human beings. Subsequently, Nussbaum takes advantage of the term 'decent' in order to restate her idea about a life with dignity (e.g. see Nussbaum 2006: 156-7, 166, 179, 185, 186):

> But we must begin by evaluating the innate power of human beings, asking which ones are the good ones, and the ones that are central to the notion of a decently flourishing human life, a life with human dignity (Nussbaum 2006: 366).

> […] a central part of our own good, each and every one of us – insofar as we agree that we want to live on decent and respectful terms with others – is to produce, and live in, a world that is morally decent, a world in which all human beings have what they need to live a life worthy of human dignity (Nussbaum 2009: 274).

Thus, the concept of human dignity and a dignified life is so close to the concept of a decent life that in her book asking 'what is the life worthy of human dignity?' is the same as asking 'what is decent for human beings?'

Furthermore, we should also remember that the central concern of dignity as decency is the 'entitlements' of human beings. Dignity as decency attempts to describe what entitlements should be provided for human beings so that they have a decent condition in their life; to live a life compatible with human dignity. As will be explained, the central element in Nussbaum's Capabilities Approach also has to do with determining the key entitlements of dignity-bearers. Hence, it would be natural that she is attracted to the decency concept of dignity.

It is essential to notice that the moralised concept of dignity as decency (which is used by Nussbaum) is not detached from Kantian dignity as value. Therefore, we can still find strong links between the meaning of dignity as decency used by Nussbaum, and the Kantian meaning of dignity as valuable status. However, the main characteristic of dignity as decency is that it is not inalienable: we can talk about losing a dignified condition for human beings, i.e. entering into a condition which is not decent for human beings. People might be in a situation in which they can benefit from their entitlements or, in contrast, their dignity might not be respected decently and as such they might not be able to benefit from their entitlements.

2.6. Nussbaum's Theory of Dignity

In the previous section I explained that the notion of dignity has two morally valid meanings in the works of Nussbaum, namely dignity as value and dignity as decency. Dignity as value reflects the general sense of human dignity which is inalienable whereas dignity as decency refers to the decency of the condition that a human being is in. In this part, I am going to elaborate on Nussbaum's *theory* of dignity in order to identify what it is in virtue of that one has dignity, in her view. As was mentioned earlier, Kant maintains that human beings are valuable for their capacity for rational agency. I also addressed some of the criticisms against Kantian dignity. Nussbaum is among those who disagree with Kant's only-rationality-criterion.

In this part, I will unpack Nussbaum's theory of human dignity. To this end, I will begin by explaining Nussbaum's objections against Kant's theory of human dignity. Subsequently, I will elucidate Nussbaum's own theory of dignity, according to which human beings are valuable not only for their capacity for rationality, but also for the capacities belonging to their sociability and animal aspects. Hence such theory, in contrast with a Kantian one, is able to cover all human beings as dignity-bearers. There are many criticisms of different aspects of Nussbaum's Capabilities Approach. However, here the specific issue is Nussbaum's theory of dignity and this has been criticised in particular by Rutger Claassen. I will address his objections and I will illustrate that his doubts against Nussbaum's theory can be removed by investigating (and carefully articulating) Nussbaum's arguments. All in all, I think Nussbaum's theory of dignity is sufficiently reasonable and justifiable for the purpose of this thesis, i.e. for the purpose of identifying ethical principles for hospital designers.

2.6.1. No to the Rationality-Only Position

Nussbaum's Capabilities Approach begins from the notion of a life that is worthy of the dignity of human beings (Nussbaum 2006: 180). In this regard, she attempts to explain the theory of dignity which can support her Capabilities Approach. However, as will be shown in the next chapter, she does not unpack her thoughts about dignity in one place, and as such they are scattered throughout her arguments concerning social justice, animal rights, and so on. Therefore, in order to explain Nussbaum's account of dignity, we need to investigate her works and gather the related arguments into a coherent whole in order to be able to address the vague aspects of her position.

Nussbaum has described her account of dignity as both neo-Aristotelian (Nussbaum 2008: 359; Nussbaum 2006: 217) and Aristotelian-Marxian (Nussbaum 2006: 278). In order to defend and develop her understanding of dignity she starts with a comparison between her notion of dignity and the kind of dignity to be found in various rationalistic theories: in the *Frontiers of Justice* she criticises the rationalistic Kantian account of Rawls on personhood, whereas in the *Human Dignity and Political Entitlements* she criticises the Stoic roots of the rationality-only conception of human dignity of which Kant is the most influential modern exponent.

Nussbaum has two sorts of objections against the rationality-only position of Kant. In the first sort, she directly criticises the idea that human rational agency is the only valuable source of human dignity. The other kind of objection does not *directly* criticise the rationality-only idea but rather shows the failure of the *consequences* of Kantian dignity, such as its failure to categorise all members of human beings as dignity-bearers. While I defend the latter sort of objection, I will explain that the former kind of criticism is not forceful. This is because, in my opinion, we do not have any method of securely assessing the suggested valuable matter on the basis of which it is claimed that we have our dignity: how can one show that, for instance, rationality (or the soul, or some capability, or the image of God) is not *the* incomparable and unconditional valuable thing in human beings which endows them a valuable status – namely dignity? What we can do, however, is to assess the consequences of a theory of dignity to see if it is compatible with already accepted elements of human dignity.

For example, we do not have any method of assessing Kantian theory so as to determine with certainty whether it is *really* (only) rationality in human beings which causes them to be dignity-bearers. Therefore, we cannot directly assess the rationality-only criterion. However, since it is widely accepted that *all* human beings have dignity, we can accordingly refute Kant's theory of dignity for its failure to cover all human beings – i.e. for not including marginal cases.

Having given the above explanations, I would like to critique Nussbaum's direct attacks against Kant's rationalistic theory. She militates against 'the Kantian split between personhood and animality' by giving four reasons (Nussbaum 2006: 132-134). Firstly, the Kantian theory of dignity denies "the fact that our dignity just is the dignity of a certain sort of animal. It is the animal sort of dignity, and that very sort of dignity could not be possessed by a being who was not mortal and vulnerable" (Nussbaum 2006: 132). In other words, Nussbaum claims that any entity which possess dignity has its *own type* of dignity; and, furthermore, that the characteristics of human dignity cannot be separated from their natural features. Therefore, such a theory of human dignity cannot be detached from the real nature of human beings. In

the same way that the 'beauty of a cherry tree in bloom' cannot be possessed by a 'diamond', for Nussbaum, the dignity of Angels (i.e. Kant's other rational beings) is not of the same kind as human dignity (Nussbaum 2006 :132).

However, I think, Nussbaum's reasoning can be refuted by Kant's advocates. Of course, the beauty of diamond and the beauty of a cherry tree is not the same; however, what is attractive in these two different things is their 'beauty' – the beauty of the cherry tree in bloom and the beauty of the diamond. Similarly, the proponents of Kant can say that although we admit that the rationality in humans and Angels is different, what gives 'value' to both of them is their 'rationality'. The natural aspects of human beings determine their specific kind of rationality (and accordingly their kind of dignity), but we cannot accordingly infer that their natural aspects are valuable, too.

The general point that Nussbaum apparently endeavours to make is that the beauty of a diamond is the beauty of something which is unchanging whereas the beauty of a 'cherry tree in bloom' has different stages; from when the tree starts its growth to the time that it is in bloom, and probably when it declines. Therefore, the nature of these two kinds of beauty is different. However, again, while a Kantian can openly accept that the beauty of these two are different in nature, the Kantian can still claim that it does not matter which period of life the tree is in, the main point still concerns its 'beauty'. The only difference is that the beauty of a diamond is inviolable and the beauty of a cherry tree in vulnerable and changeful.

I do not think that Nussbaum articulated her example adequately enough to effectively criticise Kantian dignity. The real difference between the Kantian theory of dignity and Nussbaum's is not to be found in different *types* of dignity; rather, it has to do with the *sources* of dignity. As will be explained below, unlike Kant, Nussbaum sees the value of human beings not only in their capacity for rationality, but also in the animal aspects of their lives which deeply depend on the world; this is the core difference between Nussbaum's and Kant's dignity.

According to Nussbaum, the vulnerable, transient, and natural aspects of human beings are themselves both valuable and sources of dignity. In this regard, Nussbaum's point could have been conveyed more accurately if she had said that it is not only that the cherry tree is beautiful when it is in bloom, but also in all periods of its life – from the beginning to the end; and not only is its bloom beautiful, but also its leaves, its branches, and even its roots. The actual contrast in this way would not be between two *kinds* of beauty; it would have to do with the *sources* of the things which make the tree beautiful. This example would have been more compatible with Nussbaum's multi-source conception of dignity.

What would be the answer of Kantian advocates if Nussbaum had argued in such a way? In

my view, nothing. This is because, although there are many theories of aesthetics, there is no generally accepted criterion by which we can establish conclusively what is beautiful and what is not. Therefore, one person may say that the cherry tree is beautiful only when it is in bloom, and another may say that they like all periods of the tree's life. In the same way, it is hard to directly refute the claim that it is only rationality which is valuable; nor can it be rejected if another says that all human capabilities are valuable. The only way we can refute such theories, in my opinion, is to consider the consequences of each theory and see if they are reasonable.

As to the second problem of splitting rationality and animality, Nussbaum claims that "the split wrongly denies that animality can itself have a dignity. Thus it leads us to slight aspects of our own lives that have worth, and to distort our relation to the other animals" (Nussbaum 2006: 132). I admit that the animal aspects of human beings can be considered as sources of dignity, however in this specific argument we should consider two essential points. Firstly, Nussbaum has to distinguish between the issues related to the *meaning* of dignity, and those which are pertinent to the *theory* of dignity. It seems that Nussbaum is not adequately precise in this respect in the above argument.

In these sentences, the concept of dignity is apparently used as merely a synonym for the term 'value' ("it leads us to slight aspects of our own lives that have worth"). Nussbaum's point is that the animality of human beings is also 'valuable' and, for this purpose, she attributes dignity to the animality of human beings. However, it should be noted that - for Kant - dignity, as explained previously[36], is not simply a synonym for value and worthiness. In Kant's view, those things which have price have value too.

Therefore, to reply to Nussbaum's point, a Kantian scholar may refer to her quotation and agree that animality has value and price, but point out that this does not mean that we must believe in the dignity (as an inherent and incomparable value) of animality: not every valuable thing has dignity. (We should note that Nussbaum can also claim that the value of animality is beyond price because the 'animal sort of dignity' is a sort of dignity; and that Kantian advocates cannot refute this. Again, this is because we do not have a criterion by which we can straightforwardly demonstrate the real source of dignity. Therefore, neither Kantians nor Nussbaum can directly refute the suggestion of the other side.) Furthermore, to avoid distorting 'our relation to the other animals', some scholars have attempted to explain our duty towards non-rational nature within a Kantian framework (see for example O'Neill 1998), which means that Kantian theory does not necessarily lead us to distort our *relation* to other animals.

[36] See section 2.3.1.

Nussbaum's third issue with Kant's rationalistic approach concerns the risk of ignoring the needy nature of personality. Kant presents human personality as if it were self-sufficient rather than deeply needy and dependent. "In so thinking we greatly distort the nature of our own morality and rationality, which are themselves thoroughly material and animal; we learn to ignore the fact that disease, old age, and accidents can impede the moral and rational functions, just as much as the other animal functions" (Nussbaum 2006: 132). The moral agency of human beings, Nussbaum believes, is deeply connected to their animal functions, and if we solely emphasise rationality then we may forget that the functioning of rationality in many respects depends on the functioning of animality (i.e. non-rationality).

I admit the profound connection between the function of rationality and the animal aspects of human beings. I will also express my agreement with Nussbaum's arguments in which she values a set of capabilities (instead of merely rationality) as sources of dignity. However, the above point by Nussbaum is not sufficient to attribute dignity to the non-rational aspects of human beings. An advocate of a rationalistic Kantian theory can reply that the connection between the function of rationality and of the capacities of human beings does not necessarily imply that we should consider those non-rational aspects of humans as the sources of *dignity*. We should not forget that the question of the theory of dignity is just that: for what reason does one have dignity (or, in Kantian terms, incomparable and unconditional worth)? We may find that many aspects of human beings have a valuable function but this does not mean that those valuable aspects have dignity – i.e. have incomparable and unconditional worth.

Moreover, we can interpret the relation between the rational aspects of humans and their animal aspects from within the Kantian perspective, by analogy to the relation between soup and its container (e.g. a bowl). When hungry what is of value is the soup and not its container, even though one could never have soup unless one has something to make the soup in (i.e. the container). Without the animal aspects of human beings, similarly, there would be no rationality for human beings. However, when we want to find *the thing* that is valuable in human beings, for Kant, it is human rationality.

Nussbaum's final point is that Kantian rationality has an 'atemporal' feature, "which does not grow, mature, and decline, but rather like something that is utterly removed, in its dignity, from these natural events". If we think in this way, she holds, then we may forget that in some periods of our life cycle we are extremely dependent creatures, "in which our functioning is very similar to that experienced by people with mental or physical disabilities throughout their lives" (Nussbaum 2006:132-133). This, in Nussbaum's opinion, is the other problem of splitting the rational and animal aspects of human beings in Kant's theory of dignity.

However, what Nussbaum takes this argument to expose as a problem for Kantian dignity from another point of view can be interpreted as a strength of the theory. As explained above, according to a common interpretation of the Kantian perspective, so long as a person has a potential for rationality then she has dignity. Therefore, so longs as a person is a human being (i.e. infant, young child, mature, or old), she has dignity and deserves to be respected for her dignity (unless she belongs to a group of people who lose their potential – and this is the real problem of Kantian dignity). Hence, if Kant could suggest a formulation which defines dignity for human beings that is independent of the stage of their lives, it could be considered a positive aspect of his theory, rather than being a problem.

In summary, Nussbaum's four reasons for viewing Kant's ignoring of human animality as problematic can all be replied to by Kantian scholars. As explained above, this is mainly because the correct source of dignity cannot be definitively settled owing to the fact that we cannot directly prove or establish that X is the source of dignity. However, Nussbaum also questions the *consequences* of Kant's rationalistic dignity; a criticism which I think is more reasonable than the previous one. Nussbaum challenges Kantian dignity for not covering the dignity of marginal people (Nussbaum 2006: 98). She also believes that animals are valuable and have their own type of dignity; she disagrees with the Stoics who think that it is fine to use them merely as means (Nussbaum 2008: 354). Now, it is time to elaborate Nussbaum's theory of human dignity.

2.6.2. Sources of Dignity in Nussbaum's View

What I showed in the above arguments was that Nussbaum's reasoning is not sufficient to *demonstrate* that non-rational aspects have dignity. However, there is a bigger picture behind her discussion which concerns how confining dignity to rationality in the Kantian way leaves whole areas of our moral life unexplained (or unjustified), if not ignored. In contrast to a rationalist who tries to prove everything, Nussbaum seeks a picture in which understanding things in a certain way can be seen to be more plausible, more true to our experience, more helpful, than in another.

In such a different picture of the sources of dignity of human beings, Nussbaum believes human beings are valuable not only because of their capacity for being autonomous, but also because of their other capabilities for "various forms of activity and striving" (Nussbaum 2008: 358). Nussbaum takes this idea from the Aristotelian notion of "political animals", which considers the sociability of human beings as the other source of human dignity. On this

view, human dignity "rather than beings opposed to […] animal nature, inheres in it" (Nussbaum 2006: 87).

This idea of human dignity is completed with "some help from the young Karl Marx" (Nussbaum 2008: 357), in which Marx's conception of "rich human need" (Nussbaum 2006: 132) suggests that "we are needy temporal animal beings who begin as babies, and end, often, in other forms of dependency." (Nussbaum 2006: 160). In this way, Nussbaum couples the animal and rational aspect of human beings as a unified matter in virtue of which we have dignity. From such a perspective all aspects of animality are valuable, one of which is rationality. For Nussbaum, however, sociability has the same value as rationality in human beings. In this regard, 'bodily need' is one aspect of dignity rather than being something in contrast with dignity (Nussbaum 2006: 159 – 160).

In this regard, Nussbaum maintains that human beings have some central capabilities[37], each of which is an end and should be respected in order that such a life be commensurate with dignity. As each of these capabilities are an essential aspect of human animality if someone has any one of them then they are a possessor of dignity:

> [I]f a creature has *either* the capacity for pleasure and pain or the capacity for movement from place to place *or* the capacity for emotion and affiliation *or* the capacity for reasoning, and so forth (we might add play, tool use, and others), then the creature has moral standing (Nussbaum 2006: 362, emphasis in original).

In this framework, Nussbaum has depicted a theory of dignity which not only views full rational agents as having dignity, but also views marginal people and animals as dignity-bearers: mentally and physically disabled people have dignity since they have the potential of at least one of those capabilities, even if they do not have the capability of rational agency. Young children also possess dignity as they have the potential for striving not only for rationality, but also for their other capabilities (Nussbaum 2008: 363)[38].

[37] Nussbaum has suggested a list of central capabilities which I will elaborate on in section 3.1.3.2.

[38] There are some inconsistencies in Nussbaum's arguments, in this regard. For example, she states that "we would not accord equal human dignity to a person in a persistent vegetative state, or an anencephalic child, since it would appear that there is no striving there, no reaching out for functioning" (Nussbaum 2008: 363). However, this is not in line with her other arguments about the dignity of individuals who have either of those capabilities (this, for me, can involve the capability of life). For instance, she points out that "any child born into a species has the dignity relevant to that species, whether or not it seems to have the "basic capabilities" relevant to that species" (Nussbaum 2006: 347).

All in all, Nussbaum's theory of dignity, unlike the Kantian one, has the advantage that it can recognise all members of the human species as dignity-bearing beings. This is an important aspect of Nussbaum's idea about human dignity and is considerable in the context of hospital environments, particularly when designers plan for mental hospitals. However, it is not the only reason for selecting the Capabilities Approach for this thesis. What is substantial is not just that it avoids the problem of marginal cases; but that in highlighting a range of capabilities, it highlights a range of ways in which we are vulnerable as embodied animals – a range of vulnerabilities that should be borne in mind by hospital designers.

I think what we have seen so far is an account that looks at first glance to be a defensible account of dignity (at least for the purposes of this thesis). However, before adopting her approach, we should first consider some relevant objections to her account of dignity. Scrutinising her theory may bring up some questions. This is, admittedly, because she does not sufficiently develop the different aspects and implications of her conception of dignity. Therefore, I think, Nussbaum needs to render a more comprehensive picture of her account of dignity.

2.6.3. Claassen's Objections

2.6.3.1. The Function of Dignity in Nussbaum's Theory

The Capabilities Approach has been discussed from different angles. However, Rutger Claassen in particular has objected to Nussbaum's theory of human dignity, and I will now discuss his arguments. As the first concern, Claassen wonders "what theoretical work the concept [of dignity] is actually doing" in her theory (Claassen 2014: 245). This argument reminds us of Macklin's objection[39]. One of the general objections against the notion of human dignity in bioethics was that it adds nothing to biomedical arguments. The general objection against dignity, however, focused on the vagueness of the notion of dignity. I tried to reflect the major reply to this objection, arguing that the concept of dignity has some meanings other than the abstract Kantian dignity. However, I admitted that the concept has some level of ambiguity, emphasising that we should see the concept of dignity as a general idea or a doctrine that can underscore and lead us towards a recognition of the important aspects of

For the purposes of this thesis, I will go with the second direction in which all members of human beings are considered as dignity-bearers.

[39] See section 2.4.1.

human life.

Claassen's objection, however, specifically concentrates on the role of dignity in Nussbaum's theory, arguing that it does not actually help to identify the relevant capabilities. To unpack this criticism, Claassen claims that Nussbaum has not used the concept of dignity in providing the list of basic capabilities[40]. Accordingly, he imagines two plausible functions for dignity:

> So either Nussbaum thinks with the benefit of hindsight that dignity as an invisible hand had been implicitly guiding her selection process all along (this seems unlikely), or that the work the concept is doing lies not in the selection of basic capabilities, but rather in motivating why these capabilities deserve respect at all. This last option seems more plausible. [… Therefore] the main function of dignity for Nussbaum is that it gives us a reason to respect the capabilities of humans and animals (Claassen 2014: 245).

Subsequently, Claassen poses a question: how could dignity motivate us towards an attitude of respect, in this sense? Nussbaum's answer to this question, as Claassen claims, is that it is because there is something 'wonderful' and 'awe-inspiring' in humans and animals. Claassen objects to this idea on the grounds that there are many wonderful things, such as his iPad, which are not deserving of respect. As Nussbaum herself does not comprehensively deal with the different aspects and implications of her conception of dignity, it is hard to assess such criticisms. Therefore, further clarification is needed from Nussbaum. However, it seems it is still possible to address Claassen's concern by depicting a different understanding of Nussbaum's theory of dignity.

To deal with Claassen's concern we should remember that there are two valid senses of dignity in Nussbaum's work – namely; dignity as value and dignity as decency. As was explained earlier[41], Nussbaum has used conceptions of dignity with these two meanings. However, since she herself does not consider (or might not notice) such a difference in these meanings of dignity, when her arguments flip between these two meanings some critics, such as Claassen, are moved to raise questions. As Claassen argues, it is important to figure out how the idea of

[40] After determining capabilities as the sources of human dignity, Nussbaum has emphasised that not all human capabilities are valuable. She states that there are certain key capabilities which are essential for the minimally dignified life. In this regard, Nussbaum suggests a list of ten basic capabilities as the central capabilities which one should be able to practice, develop, and secure in order to have a life with human dignity. I will develop this idea in the next chapter (see section 3.1.). Claassen's claim, however, is that the concept of dignity has no role in determining Nussbaum's list of central capabilities.

[41] See section 2.5.7.

human dignity works in Nussbaum's theory. Nussbaum explains that her Capabilities Approach begins with an *intuitive* idea of human dignity. However, we should notice that Nussbaum utilises both meanings of dignity – i.e. dignity as value and dignity as decency – as such a basic idea:

> The basic intuitive idea of my version of the capabilities approach is that we begin with a conception of the dignity of the human beings, and of a life that is worthy of that dignity […] (Nussbaum 2006: 74).

If I want to interpret this in the context of the double-meaning concept of dignity, then I would say that the Capabilities Approach is based on the notions of human 'value' and the 'decent' life which such value deserves. As such, the Capabilities Approach considers both the value of human dignity *and* a decent condition for human beings. Thus, we need to clarify in which uses of the concept of dignity she aims for 'value', and where she is instead concerned with 'decency'.

Nussbaum's theory of dignity includes two steps. In the first one she lays the foundation of her theory of dignity, in which dignity is about value and worthiness. In this step, as quoted above, Nussbaum attempts to convey the sense in which human beings have value (i.e. dignity) because of their capacities for striving activities. This is the basic and the central idea of her Capabilities Approach. In this step, the concept of dignity is utilised as 'value' and 'worthiness'. However, Nussbaum does not stop with this step and tries to advance her arguments about capabilities.

In the second step Nussbaum endeavours to be more specific in identifying the capabilities in virtue of which human beings have dignity. This is because, in Nussbaum's view, not all capabilities are valuable, and therefore some capabilities cannot be sources of human value:

> The capacity for cruelty, for example, exerts no claim on others that it be developed because, when we consider that capacity, we do not conclude that it is necessary for living a life that is worthy of the dignity that human beings possess (Nussbaum 2008: 357).

Accordingly, she needs to discover what capabilities should be supported in order to have a decent life (or at least a minimally decent one). This is the second step in Nussbaum's theory, in which dignity as decency can help us to understand her view. As can be seen in Nussbaum's work, in this step she makes wide references to the notion of a 'decent and dignified life'. Having made this clarification, we can now return to Claassen's concern: what is the function of these conceptions of dignity in identifying the relevant capabilities?

As has been said, this sort of concern about the role of dignity in Nussbaum's theory would best be addressed by Nussbaum herself. However, to the extent that I understand her theory, it seems that the concept of dignity works as a criterion for determining the basic capabilities of human life:

> I argue that the best approach to this idea of a basic social minimum is provided by an approach that focuses on *human capabilities,* that is, what people are actually able to do and to be, in a way informed by an intuitive idea of a life that is worthy of the dignity of the human being. I identify a list of *central human capabilities*, arguing that all of them are implicit in the idea of a life worthy of human dignity (Nussbaum 2006: 70).

Therefore, from this perspective, by imagining a decent life for a human being, we can discover the basic capabilities which are necessary for such a life. In other words, the conception of 'a decent life for a human being' can *direct* (and not merely motivate, as Claassen supposes) thinkers to find the central capabilities. However, the notion of a 'decent life' is itself vague, and some may ask: how can such a vague idea lead us to find the basic capabilities? While Nussbaum admits that the concept of dignity is vague, she is still optimistic about the ability of the notion of dignity in handling this mission – i.e. in finding basic capabilities – by being careful to talk about only a non-metaphysical dignity.

Nussbaum believes that we can reach what John Rawls calls an 'overlapping consensus' (Rawls 2005: 150) on the basic capabilities: the overlapping consensus can be reached if we "make adjustments in the way in which we talk about human capacities and their realization that […] can be accepted by many different religions and secular conceptions" (Nussbaum 2008: 361). For this purpose, we need to articulate the concept of dignity "in a way that shows the ethical core of that idea but that does not insist on linking it to involved metaphysical or psychological doctrines concerning which the major religions and secular conceptions differ" (Nussbaum 2008: 361).

This is the approach which was already successfully undertaken by the framers of the Universal Declaration of Human Rights:

> The framers of the UN's *Universal Declaration of Human Rights* were conscious of their profound religious and philosophical differences. As Jacques Maritain writes, however, they could agree on the idea that the human being is an end and not merely a means, and their account of human rights embodied a practical political agreement deriving from this shared intuitive idea, which different religions would then interpret further in different ways (some in terms of the idea of the soul, and others eschewing

> that concept, for example). Like Maritain, […] I think we ought to seek political principles that have a moral content but that avoid contentious metaphysical notions […] (Nussbaum 2008: 360 – 361).

All in all, by having a non-metaphysical concept of human dignity, Nussbaum believes, we can find the basic capabilities, the ability of flourishing which indicates a decent (dignified) life. However, Nussbaum needs to clarify what aspect of dignity should be non-metaphysical. I assume that she is talking about the implications of the concept of dignity, rather than its theory. I assume this because it is difficult to determine the sources of human dignity without a religious or a metaphysical doctrine. Nussbaum's own theory – i.e. humans have dignity in virtue of their capabilities – has its own Aristotelian-Marxian doctrine, which might itself be opposed by those for whom human begins are valuable not for their materialistic aspects, but for their soul, spiritual dimensions, or their image of God. Therefore, in my opinion, it is hard to claim that one can have a non-metaphysical *theory* of human beings.

However, even though people's ideas about the *sources* of human dignity may vary, I think they can still agree with the *implications* of this conception. This means that despite someone believing that a human being is valuable, for example, in virtue of her soul (or her rationality, or her capabilities, or the like), they can agree with advocates of other theories of human dignity on the point that we should respect human beings; that we should see them as ends and not merely as means; that we have a duty towards them and that they have certain entitlements. Hence, if it were agreed that all human beings are worthy and equal, and while they have certain entitlements they should always be treated as ends, then we would have a non-metaphysical concept of human dignity.

Such a conception, then, can intuitively lead us to discover the key capabilities which are minimally needed for a decent life. This is the function of the concept of human dignity in Nussbaum's Capabilities Approach, in my view. However, as was mentioned earlier, Nussbaum herself accepts that such a concept of dignity is vague and cannot straightforwardly show the basic capabilities by itself; "it must be done by discussing the relationship for the putative entitlement to the other existing entitlements, in a long and detailed process" (Nussbaum 2011: 32).

> "[The evaluation of capacities] is slippery and delicate, because we are moving back and forth between thinking of capacities and thinking of a flourishing life, and there is need both for sensitive imagination and for lots of cross-checking in the theory, as when we arrive at some political principles based upon our intuitive idea and then see how they look." (Nussbaum 2008: 357 – 358).

Overall, I think, the point that Nussbaum is trying to convey about the function of dignity in her theory is that although the concept of dignity is vague, it can lead our thoughts in such a direction so as to encourage us to discuss our capabilities and the flourishing that can lead to a decent life. In my view, as I mentioned before in addressing Macklin's objection, we should see the notion of dignity as a doctrine or an idea, which functions as an indicator as to the key conditions of human life in which one has a life compatible with one's value. But as it is not exactly clear which capabilities are necessary for a decent life, we need to discuss the issue and work together so as to reach an overlapping consensus. Reaching this universal agreement is possible, in Nussbaum's view, as we have already had such an experience with human rights. Consequently, Nussbaum's big picture concerning her theory of human dignity is in many respects different from what Claassen depicts it as.

2.6.3.2. Is It a Circular Argument?

Claassen has also identified another difficulty with Nussbaum's theory of dignity, and although it concerns the way she used her Capabilities Approach with respect to animal rights, the basis of Claassen's objection is related to Nussbaum's theory of dignity. Nussbaum claims that if a being has any central capabilities then it has a moral standing – i.e. it has its own type of dignity (Nussbaum 2006: 362). With regard to such a broad notion of dignity Claassen is concerned about the extension of dignity to animals: "it would seem to set no limit at all to the extension of dignity. Plants also function in certain ways, and maybe ecosystems do so as well – plants can flourish or perish, ecosystems can be stable or degrade" (Claassen 2014: 346)[42].

To avoid becoming trapped in such concerns Nussbaum adapts a Utilitarian suggestion, in which the category of entitled animals is limited to only sentient ones. While Claassen accepts that this strategy can distinguish creatures with dignity from other natural phenomena, this solution is not available in Nussbaum's own theory and thus it makes her theory circular. This is because Nussbaum has suggested a list of ten capabilities as central for human life and of course, since this list has an animal basis, unsurprisingly it includes animals as well. However, even though plants and ecosystems have their own type of functioning, they seem to be *arbitrarily* excluded with no explicit reason:

> Her argument is circular: first she defines a list of capabilities shared by humans and animals, and then she concludes that humans and animals (but not plants and

[42] Indeed, some theorists have tried to extend the Capabilities Approach to provide a basis for a theory of ecological justice (e.g. Schlosberg 2007).

ecosystems) fit the bill (Claassen 2014: 247).

To address this objection, we should consider again the two separate, but not distinct, steps in Nussbaum's account of dignity. The first step concerned Nussbaum's general idea on the sources of *human* dignity. In this regard, she suggested that human beings are valuable for both their animal and rational aspects. Therefore, the first step is about finding a virtue in human beings for which they deserve to be attributed dignity. To rephrase the point more simply, it is an answer to the following question: we know that human beings are valuable (i.e. are dignity-possessors), but why?

In this light, it is natural to see that Nussbaum, in the second step, introduces the basic capabilities according to what is central for *human* flourishing. The theory is then essentially about human dignity, but also has enough room to include the dignity of animals as a result of their shared capabilities with humans. In fact, Nussbaum, as previously stated, *expanded* her theory to include nonhuman animal dignity. Consequently, because Nussbaum's theory of dignity is purposefully articulated in order to find the reason for *human* dignity (and not plants' or ecosystems') it *should* be fit for humans (and also animals as far as there are similarities in their capabilities). Hence, it is not a circular argument.

Nevertheless, I agree with the point that it is a weakness of Nussbaum's theory that it cannot exclude plants and ecosystems systematically from the list of dignity-bearers, forcing her to borrow the Utilitarian idea of sentient animals. In contrast with Kantian dignity, which was too limited to include marginal cases, Nussbaum's dignity is too wide to exclude the non-dignity-bearers by itself. However, I see no problem in adopting the sentience idea to modify the deficits of the Aristotelian-Marxian theory of dignity. In particular, this deficit does not have a negative effect in the field of hospital design, as Nussbaum's theory is fully reasonable for the human realm. All in all, although Nussbaum does not comprehensively explain the different aspects of her theory of dignity, it seems it is possible to provide replies to Claassen's objections in accordance with Nussbaum's arguments.

In summary, according to Nussbaum's theory of human dignity, human beings have value in virtue of their capacities to flourish and engage in certain activities. Although not all human capabilities are valuable some of them are identified as central, which means that they are fundamental for a life worthy of human dignity. An intuitive and non-metaphysical conception of human dignity (both as value and decency), can help us to achieve an overlapping consensus about such central capabilities.

2.7. Summary

Patients have certain rights when they need to be cured in hospitals. There is also no doubt that the hospital environment can *facilitate*, or impede, our response to such rights. Accordingly, designers have a responsibility to plan hospitals in such a way as to help ensure that patients' rights can be suitably addressed. Reflecting on the relevant literature and documents, I showed that two core notions are used for illustrating the ethical concerns of the hospital environment, namely patients' rights and human dignity.

Accordingly, designers should be expected to provide environments that are responsive to the dignity and rights of patients. However, the main question has to do with how designers can provide such an environment. Many different ways can be suggested. My proposal is to find some specific principles suitable to the context of the hospital environment and its design, with which designers can identify how they can meet their ethical duties. For this purpose we need a philosophical theory which can, on the one hand, properly connect these two central concepts of dignity and rights, and on the other hand, help us to identify the ethical principles relevant for hospital designers. My hypothesis is that Nussbaum's Capabilities Approach is the appropriate theory for this goal.

Nussbaum bases her theory on the notion of human dignity and, in this regard, I began to elaborate how this concept should be understood in the context of the theory. However, since Nussbaum did not discuss all aspects of dignity in one place, I established my arguments based on the Kantian account of dignity as an influential concept of modern dignity. It was discussed three main areas in the discourse of dignity. The meaning of dignity is the first, which from Kant's perspective is about the inherent, inalienable, unconditional, and incomparable value of human dignity.

The second main area of dignity is its implications. I counted four principal implications of Kantian dignity, namely the notion of respect for human dignity, equality, and human responsibilities and entitlements. The most controversial aspect of Kantian dignity, however, concerns the theory of dignity. For Kant, only those who have the capacity for rationality and autonomy of will possess dignity. Such a theory has been objected to for excluding marginal cases from being dignity-bearers. In contrast, Nussbaum's theory of human dignity covers all human beings, as she puts value on a range of human capacities.

According to this theory all human beings are dignity-possessors including marginal cases. This is an important aspect of Nussbaum's theory which is particularly essential in hospital design. The most important characteristic of her theory, though, is her underscoring of a range

of human capabilities as valuable aspects of human beings, which highlights the vulnerability of humans and the importance of their dependence on the external world. This is exactly what a moral designer needs to consider in order to provide an ethical environment in hospitals. Nussbaum has another difference in her account of dignity, which is her use of a further meaning of dignity.

While Nussbaum utilises the Kantian concept of dignity as value in some cases, she also refers to dignity in another sense which I call dignity as decency. This notion concerns the minimum quality of life that can be considered 'decent' for human beings. This violable sense of dignity is widely referenced in Nussbaum's work, even though she did not explicitly distinguish between these two distinct, but connected, meanings of dignity.

I also discussed some general objections against the concept of human dignity, particularly in the field of bioethics. In this regard, I classified the main objections into three issues. Firstly, was the notion that the concept of respect for dignity is equal to respect for autonomy. This claim was rejected for various reasons, the most important of which was that marginal people have dignity, even though they are sometimes not autonomous. Therefore, respect for dignity is not equal to respect for autonomy.

The second main objection was that dignity is a vague concept and adds nothing. The third objection was that dignity sometimes seems to be an inalienable notion and at other times seems violable. While I admit that the concept of dignity is vague, I explained that it is similar to other core ethical notions. It is not a weakness of dignity, it is vague because of its richness, and we should consider this notion as a general idea or doctrine which leads us to take into account important features of human life. It was also mentioned that the concept of dignity has some meanings other than the inalienable conception of Kantian dignity which are violable, such as the concept I suggested (i.e. dignity as decency).

Overall, in this chapter, I have tried to establish the main theoretical aspects of human dignity owing to its being the basic concept in the field of ethical hospital environments. In the next chapter I will consider the more practical aspects of Nussbaum's conception of dignity, namely the implications of human dignity, and I will show how Nussbaum links this notion to the idea of human entitlements. Finally, having explained the practical ideas of the Capabilities Approach, I will try to bring the notions of human dignity and entitlement into the context of the hospital environment.

Chapter 3

3. Entitlements in the Hospital Environment

3.1. Nussbaum's Implications of Dignity

3.1.1. A Review of the Arguments

In the previous chapter, I explained that there are two notions which play a central role in determining the ethical concerns related to hospital environments – namely the dignity and rights of patients. Correspondingly, it is expected that designers undertake certain ethical responsibilities towards patients. In other words, hospital designers are not only responsible for providing a suitable place for the treatment process; they also have to consider the non-medical requirements of patients in hospitals and identify how they can prepare the hospital environment for such needs.

Although the two concepts of 'human dignity' and 'patients' rights' are widely referred to in in the relevant documents (in order to underscore patients' expectations of the hospital environment), we need to introduce a system in which these concepts can lead designers to identify their ethical responsibilities. Therefore, we need to determine an appropriate conception of human dignity and elucidate the way in which it can be linked to the notion of patients' rights so that it illustrates the main ethical expectations of the hospital environment.

The hypothesis of this thesis is that designers can reach a more practical and clear understanding of human dignity and patients' rights, in the context of the hospital environment, if they adopt the key elements of Nussbaum's Capabilities Approach. This is because the core of this theory concerns understanding the basic entitlements of humans as the minimum condition of a life worthy of human dignity. In the previous chapter, I elaborated upon the theoretical aspects of Nussbaum's notion of dignity. I based my elaboration of Nussbaum's notion of dignity on three vital areas of Kantian dignity – i.e. the meaning, the implications and the theory of dignity. Subsequently, I explained what features of Kantian dignity are changed (or developed) in Nussbaum's notion of dignity, with particular concern for the 'meaning' and the 'theory' of dignity.

It was argued that there are two meanings of dignity used by Nussbaum: one is the general Kantian sense which functions as a synonym of 'value' and 'worthiness'; and the other refers to the notion of a 'decent life'. This latter meaning of dignity is instrumental in linking the

general abstract meaning of dignity as 'value' to practical concerns, i.e. the quality of life. Nussbaum's theory of human dignity, however, portrays a different idea from that of Kant. Nussbaum believes that human beings are valuable not only for their rationality – as Kant states – but also for a range of capacities involved in the various dimensions of their flourishing as a kind of embodied animal. What is essential in Nussbaum's notion of dignity are human capabilities to flourish and strive in various activities.

In comparison with Kant's theory of human dignity, Nussbaum's approach has several important advantages which are instrumental for designers in identifying their ethical responsibilities. As mentioned before, Kantian dignity puts value solely on rationality. It would seem to be hard for a designer to be led by such an abstract notion: people in hospital are seeking support for their physical or mental impairments and it is not clear that focusing on their rationality is the best way to help designers identify all the requirements of these patients.

In contrast, from Nussbaum's Aristotelian-Marxian point of view, what is wonderful in humans is their capacity to flourish and their needy nature - which is both vulnerable and profoundly dependant on the external world. This conception, in contrast to the previous one, can inspire designers when planning for people who might be extremely dependant on the support of others to reach the minimum capability level necessary for a life worthy of human dignity. This idea, accordingly, suggests to designers that they provide a fully supportive environment for the capabilities of human beings. However, this is not the only advantage of the Capabilities Approach in the context of hospital design.

The dignity of non-fully rational agents in the Kantian perspective is questionable. Although, as discussed before, there are many interpretations of Kantian dignity that have sought to recognise the dignity of marginal cases there is no satisfactory interpretation of Kantian dignity according to which the severely mentally ill are identified as dignity-bearers. On the other hand, the Capabilities Approach, which employs an inclusive concept of dignity, has as one of its main concerns the recognition of disabled people as dignity possessors. Obviously, this aspect of Nussbaum's theory can profoundly impact on the quality of the design of mental hospitals.

What is mentioned above mainly reflects the *theoretical* advantages of the Capabilities Approach, i.e. the positive aspects of Nussbaum's account of dignity in terms of 'meaning' and 'theory'. However, the prominent features of the Capabilities Approach appear more vividly in the practical aspects of the Capabilities Approach, namely in those issues which are pertinent to the 'implications' of Nussbaum's dignity. Accordingly, there are some other

advantages to adopting the Capabilities Approach for the issue of hospital design which will be mentioned when discussing the implications of Nussbaum's notion of dignity. In this chapter, I will discuss the implications of Nussbaum's dignity as the practical aspect of this notion. Subsequently, I will illustrate how Nussbaum's thoughts can help us define the main ethical entitlements of people in hospitals.

In section 2.3.2., I explained that the Kantian account of human dignity has certain implications (elements) – e.g. respect for dignity, human rights (entitlements) and responsibilities, and equality – which are principal in bringing this notion into practical contexts, such as hospital design. However, I have not yet elaborated upon the implications of Nussbaum's notion of dignity. While the discussion in the previous chapter was focused on the theoretical aspects of human dignity in the Capabilities Approach, I would now like to address the implications of the Capabilities Approach in the context of the hospital environment. In this way, I hope to develop a more precise understanding of the ethical requirements of people in hospitals.

For this purpose, I will base my arguments for the four central implications of Nussbaum's dignity on the same Kantian implications of human dignity. Concerning the notion of 'respect', I will explain that according to the Capabilities Approach respect for human dignity is not merely seeing others as ends; it also implies that we all have a duty to support the capabilities of each other. In terms of human 'entitlements', I will elaborate on Nussbaum's suggested list of ten central human capabilities. She believes that to have a life worthy of human dignity one should be able to practice one's central capabilities, at least up to a minimum level (which she calls the *threshold* of capabilities). I will also critique some relevant aspects of her list of capabilities, even though I will show that those deficiencies are not important in the context of the hospital environment.

In terms of human responsibilities, I will illustrate the reasons for thinking that designers have an ethical responsibility to provide for the capabilities of hospital users. Subsequently, the role of institutions in addressing the rights of citizens will be discussed. And finally, in terms of equality, I will argue that we need to support the capabilities of *all* hospital users, rather than merely the patients. Furthermore, equality can function as a criterion by which we can identify the thresholds of capabilities within a society. Firstly, in the forthcoming sections, I will investigate how the elements of dignity, as explained in the Kantian section[43], should be considered in Nussbaum's account of dignity. We will begin with the conception of 'respect

[43] See section 2.3.2.

for human dignity'.

3.1.2. Respect: Supporting Capabilities

In the previous chapter it was explained that, for Kant, the proper action towards the dignity of human beings is called 'respect'. Respect for human dignity in Kant's perspective, however, has a crucial and famous characteristic: to respect human beings is to treat them not merely as means, but at the same time as ends. Nussbaum essentially adopts this conception, emphasising that the concept of respect and seeing persons as ends are profoundly linked:

> Indeed, one good general way of thinking about the intuitive idea of dignity is that it is the idea of being an end rather than merely a means. […] This idea is closely linked to the idea of respect as the proper attitude toward dignity; indeed, rather than thinking of the two concepts as totally independent, so that we would first offer an independent account of dignity and then argue that dignity deserves respect (as independently defined), I believe that we should think of the two notions as closely related, forming a concept-family to be jointly elucidated. Central to both concepts is the idea of being an end and not merely a means. (Nussbaum 2008: 353-354)

However, this way of thinking about the notion of dignity in the context of the Capabilities Approach brings certain consequences. As was mentioned earlier, Nussbaum believes that the sources of human dignity are human capacities for flourishing and striving in various activities. Accordingly, to respect human beings we have to see human flourishing and capabilities as worthy of respect (Nussbaum 2008: 358). In other words, human beings are entitled to flourish in their capabilities, and acting for this purpose is (at least a part of) what it is to respect human dignity.

In the previous chapter, it was also explained that respect can be interpreted as the responsibility of human beings toward the dignity-bearer. In this light, and in accordance with Nussbaum's view, to respect the dignity of an individual we have a responsibility to support and provide for that individual's capabilities. This means that it is wrong to "think that respect requires only a reverential attitude. It requires more: it requires creating the conditions in which capabilities can develop and unfold themselves" (Nussbaum 2008: 359). Therefore, according to Nussbaum, in order to respect human dignity not only should we refrain from seeing dignity-bearers merely as means, but we should also support the development and exercise of their unfulfilled (or incomplete) capabilities, or at least provide the opportunity for such exercise (Nussbaum 2008: 358).

Accordingly, a failure of respect can emerge either when a dignity-bearer is instrumentalised, or when he is deprived of the opportunity to exercise his central capabilities. Nussbaum, in 'Human Dignity and Political Entitlements', renders two examples of the violation of dignity[44], each of which represents one of the aforementioned forms of failing to respect human dignity (Nussbaum 2008: 358-359). From Nussbaum's point of view, an unfairly imprisoned person is harmed "because [this] deprives the person of the opportunity to exercise his or her good capacities". Nussbaum mentions rape as an example of using a human being merely as a tool.

All in all, the Capabilities Approach suggests that to respect the dignity of human beings, not only should we avoid using human beings merely as means, but we should also endeavour to provide a suitable condition and opportunities by which they can exercise their capabilities, and thereby flourish. In this regard, our duty towards the dignity of human beings (i.e. our duty to respect dignity) is to provide for the capabilities of human beings. Thus, in order to know how to respect the dignity of others we need to determine the relevant human entitlements and responsibilities within this framework.

3.1.3. Human Entitlements

3.1.3.1. Starting from Entitlements

In Chapter two, I explained that the concept of human dignity has two important implications: duty (responsibilities), and rights (entitlements). In my view, human dignity is partly shaped by these two notions, and I previously suggested that the meaning of Kantian dignity be considered as 'valuable status' rather than 'value' or 'worthiness'. This is because 'valuable status' indicates both 'responsibilities' and 'entitlements', whereas 'value' and 'worthiness' merely indicate entitlements[45].

In the context of human dignity, 'responsibility' and 'entitlement' have the same importance. However, in practice, we may take different approaches: we may start by considering the responsibilities of moral agents and then try to detect the corresponding entitlements; or we may begin by trying to identify the entitlements of dignity-bearers and then, subsequently, attempt to discover the agents who can address those entitlements. Taking the latter strategy,

[44] As was explained earlier: given that dignity as value is inviolable, what is called a 'violation of human dignity' can be interpreted as a failure to respect human dignity.

[45] See section 2.3.2.3.

Nussbaum argues that this method should have priority over the duty-based approach (Nussbaum 2006: 275-278).

Nussbaum provides some reasons to justify beginning with entitlements. For example, Nussbaum refutes any 'purely duty-based' approach, claiming that "duties […] are never generated in a vacuum: the idea of needs, and of entitlements based upon needs, always enters in to inform us why the duty is a duty, and why it matters" (Nussbaum 2006: 276). Despite the reasons Nussbaum gives to support her rights-first method, I think that this method has another benefit for Nussbaum in that it allows her dealing with entitlements in the context of animal rights. Nussbaum's Capabilities Approach would be able to develop its arguments related to animal rights and dignity mainly because it puts the emphasis on entitlements, rather than responsibilities. If the Capabilities Approach had based its theory on the duties of dignity-bearers, it would be difficult to derive animal entitlements from the notion of animal dignity.

However, there is another advantage in starting with entitlements which I think is particularly important and noteworthy for the purpose of this thesis. Nussbaum points out the fact that there is a "multiplicity of institutional and individual actors with which [… the correlative duties towards human entitlements] must deal" (Nussbaum 2006: 278). By having the list of the basic entitlements of human beings it is easier to discover which actor has which responsibility. This is another positive aspect of Nussbaum's Capabilities Approach when addressing patients' rights in terms of the hospital environment.

This is because there are many parties (including individuals and institutions) who have a role in shaping the environment of a hospital: individuals such as engineers, architects, and interior designers who build and design the general environment of a hospital; hospital staff who may decorate the environment; hospital managers who may set rules for using or blocking certain spaces in hospitals; hospital commissioners who determine which facilities and places are needed in their hospitals; institutions such as the national healthcare organisation (e.g. the NHS in the UK) which sets rules and regulations for the construction and design of hospitals; Parliament which determines the amount of budget which should be spent on the construction and design of hospitals, and so on.

All of the above parties have a direct or indirect effect on shaping the environment of a hospital. It would be difficult to begin this task by separately considering the responsibilities of each of these actors towards patients. In contrast, if we start with the entitlements of patients in hospitals, it will be much easier to identify how these parties should contribute to the provision of decent hospital environments. For example, when we determine that in a Children's Hospital a mother is entitled to both stay with her child and have her privacy

respected, it is easier to then find the corresponding responsibilities of the pertinent parties than it would have been to have begun from the opposite direction.

The architect would know that she should provide sufficient space for both the child and her mother; the mechanical engineer would know the number of people per room to provide with fresh air and heat, etc.; the interior designer would know that there will be a stressed mother and a sick child in that room and that, therefore, while the environment of the hospital should use positive distractions for the mother to reduce her stress, it should also be calm and sufficiently child-friendly; all of these details would determine for the commissioner just how much money was needed for this entitlement in a certain hospital, and Parliament would then be able to sum the total amount of money needed for this specific entitlement. Thus, the rights-first strategy of the Capabilities Approach is a considerable motivating reason for employing this theory in discussing the ways in which the hospital environment can provide for patients' entitlements. All in all, Nussbaum's focus is on beginning with human entitlements. In the following, I will illustrate how she advances this strategy in her theory.

3.1.3.2. Ten Basic Entitlements

Nussbaum's Capabilities Approach is basically a theory of justice (Nussbaum 2006: 290). A just society should be able to provide for, at least, the minimum level of human basic entitlements. Moreover, Nussbaum states her agreement with Hugo Grotius in that dignity and sociability are the starting principles (Nussbaum 2006: 36-38). Having these premises, a focus on human rights and entitlements based on a notion of human dignity is to be expected. In this regard, human entitlements play a central role in Nussbaum's theory.

As was mentioned in section 2.6.2., according to Nussbaum's notion of dignity, human beings are valuable for their capabilities. However, this does not mean that all capabilities are sources of human dignity; some capabilities are 'good' and others are 'bad'[46], and amongst the good capabilities some are 'important' and some are (relatively) 'trivial'. Nussbaum suggests that we need to identify the important capabilities:

> There must be a prior evaluation, deciding which [capabilities] are good, and, among the good, which are most central, most clearly involved in defining the minimum conditions for a life with human dignity (Nussbaum 2006: 166).

[46] I will be returning to this issue below.

As mentioned before, to respect the dignity of human beings means to support and provide for the capabilities of human beings so that they can exercise (or at least have the opportunity to protect, develop, or exercise) their capabilities. This means that the central capabilities themselves are the source of the moral claim:

> The "basic capabilities" of human beings are sources of moral claims wherever we find them: they exert a moral claim that they should be developed and given a life that is flourishing rather than stunted (Nussbaum 2006: 278).

In other words, by defining the basic capabilities we can determine the main human entitlements. In this framework, Nussbaum believes that human beings have some central capabilities which everybody should be able to enjoy to at least a minimum level (or as Nussbaum calls it: the *threshold* level). She suggests ten central capabilities, the threshold levels of which must be met in order for people to live in a way worthy of human dignity. Her basic suggested capabilities are:

> 1. *Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.
>
> 2. *Bodily Health*. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.
>
> 3. *Bodily Integrity*. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.
>
> 4. *Senses, Imagination, and Thought*. Being able to use the senses, to imagine, think, and reason - and to do these things in a "truly human" way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to have pleasurable experiences and to avoid non-beneficial pain.
>
> 5. *Emotions*. Being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's

emotional development blighted by fear and anxiety. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)

6. *Practical Reason.* Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance.)

7. *Affiliation*.

A. Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedom of assembly and political speech.)

B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non-discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national origin.

8. *Other Species.* Being able to live with concern for and in relation to animals, plants, and the world of nature.

9. *Play.* Being able to laugh, to play, to enjoy recreational activities.

10. *Control over One's Environment.*

A. Political. Being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association.

B. Material. Being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers (Nussbaum 2006: 76 – 78).

This is the list of basic capabilities which people need to be able to develop and exercise in

order to flourish. The idea of capabilities has a profound relation to the concept of human rights as this issue (i.e. human rights) is discussed internationally. While the idea of human rights is understood in various ways, Nussbaum believes that "the best way of thinking about what it is to secure [fundamental rights] to people is to think in terms of capabilities" (Nussbaum 2003: 37). Thus, the capabilities which are listed by Nussbaum can be seen as the basis of human entitlements. It means, "for each important entitlement, there is some appropriate level beneath which it seems right to say that the relevant entitlement has not been secured" (Nussbaum 2009: 335). In this regards, Nussbaum suggests the notion of *threshold* as the minimum level of each capability which a person should be able to practice in order to have life with human dignity.

Therefore, the main concern of the Capabilities Approach is to ensure that everybody has an *adequate* opportunity to practice, develop, or have secured the central capabilities, at least, up to the threshold level of each capabilities. For the conditions above the thresholds, however, Capabilities Approach as a theory of justice does not have an answer and in this regard, it is incomplete (Nussbaum 2006: 292)[47].

3.1.3.3. The Pluralism of Nussbaum's List

Nussbaum sees her Capabilities Approach as a species of the human rights approach (Nussbaum 2006: 284), and as such she hopes that there is a reasonable chance of reaching an 'overlapping consensus' concerning the general list of capabilities in the same way that nations reached a consensus on the general outlines of human rights (Nussbaum 2008: 360-361). In this regard, an attempt is made to determine the list in a *general* way "in order to leave room for the activities of specifying and deliberating by citizens and their legislatures and courts in each nation" (Nussbaum 2006: 296).

In other words, the list should provide general goals so that it "can be further specified by the society in question as it works on the account of fundamental entitlements it wishes to endorse" (Nussbaum 2006: 75). In my view, it is not only societies that can further specify the list for

[47] It might be said that given that justice is a matter of securing entitlements (to threshold capability levels) then going over them is not a requirement of *justice.* However, I think Nussbaum is right in thinking about justice for the condition of being above the thresholds, if we consider that the realm of justice is not only in securing minimum entitlements, but also in *justly* distributing resources. (If a nation can afford not only for the basic entitlements of human beings, but also more than that, then the nation should *justly* distribute those resources).

their account of entitlements, some practical fields which are directly related to human capabilities, such as hospital design, can also take advantage of this generality.

For example, if we want to use this approach in the field of hospital design, the specification of those capabilities and their implications in this context can be different to (or be more detailed than) Nussbaum's. For instance, as will be suggested in section 3.3.2., providing 'private areas' for patients in hospital is one of the essential ethical requirements. Therefore, if we want to bring the list of Nussbaum into the field of hospital design, it can be adapted by adding this item into the definition of the tenth capability (i.e. control over one's environment) in order to have a more tailored list for the purpose of hospital design. This characteristic of Nussbaum's list of capabilities – that it can be specified with respect to different contexts – aids in the application of this list to the field of hospital environments[48].

There are some factors in providing the list of capabilities which makes it a pluralistic list (Nussbaum 2006: 296-297), to ensure that the list of capabilities is sufficiently near to the 'overlapping consensus'. Firstly, the aforementioned ten central capabilities are not the final list for Nussbaum; the list is "open–ended and has undergone modification over time" (Nussbaum 2006: 76). The important ideas in this approach are that people should be able to enjoy their basic capabilities, at least to the threshold level, and that such basic capabilities ought to be listed and defined in such a way so as to support a dignified life for people in different situations. Therefore, for instance, this thesis can benefit from Nussbaum's approach by providing some specifications for her suggested capabilities, as mentioned above.

Nussbaum tries to take a non-metaphysical approach in her provision of the list of capabilities. In my view, as argued earlier, a non-metaphysical approach is more plausible if it is considered in terms of human rights, rather than in terms of the sources of human dignity (i.e. capabilities). Given that I have already explained this aspect of Nussbaum's theory[49], I am not going to discuss it again here. The other factor to consider is that the focus of this approach is on capabilities rather than on functioning. In other words, in order to respect someone's dignity others should enable that person to exercise or develop their capabilities; but the decision of whether or not to practice that capability is a matter for the dignity possessor. Nussbaum gives the right to vote as an example:

> [A] just society offers people the opportunity to vote, but it does not require them to vote. (Voting is not acceptable to some religions, for example the Old Order Amish.

[48] See section 3.5.

[49] See section 3.1.3.5.

We respect them by working for capability, not functioning.) (Nussbaum 2008: 368).

Therefore, what is essential in the Capabilities Approach is to provide *opportunities* for agents; it is up to the agent if they wish to take advantage of the opportunities provided. This is the liberal version of the Capabilities Approach that Nussbaum favours when expanding on her theory. This direction is deeply compatible with the nature of the hospital as a facility. The responsibility of designers is to provide an environment in which people are able to enjoy their capabilities, whether or not their want to use that opportunity.

For example, the capability of Affiliation suggests that people should be able to live with and toward others. The Capabilities Approach, accordingly, would recommend to a hospital designer that she prepare patients' rooms with the ability to accommodate their family in order to respect their dignity. However, providing such amenities does not imply that patients should be forced to have visits from their relatives. In fact, the design of the hospital should be sufficiently *flexible* for the relevant human capabilities and should provide a suitable environment for people to practice (or develop, or have protected) any of their capabilities. The emphasis on capabilities rather than functioning can thus be considered another benefit of the Capabilities Approach for hospital design.

Nussbaum hopes that kinds of these characteristics (i.e. being general, being open-ended, being non-metaphysical and having a focus on capabilities rather than functioning) will increase the chance of reaching an overlapping consensus concerning the list of basic entitlements. However, there are some subtle ways in which improvements can be made – in particular Nussbaum's description of the list of capabilities can be adjusted so that the theory works better in general. Let's start with this latter point: namely, the liberal interpretation of the Capabilities Approach.

3.1.3.4. Preventing Bad Capabilities

To explain this point, we need to once again review the basis of the Capabilities Approach. It was argued that human beings have some bad capabilities and some good capabilities, and that some of those good capabilities are important. Nussbaum's list reflects the important capabilities which should be supported so that one can have a dignified life. However, we should not forget that there are also some bad capabilities (such as the capability of cruelty) which should not only not be supported, but should also be 'inhibited' (Nussbaum 2006: 166).

Human dignity, in this regard, has a dual function which is discussed in some of the literature

as 'liberal' and 'conservative' dignity[50]. To explain further: sometimes the concept of human dignity is understood in a *liberal* way as conveying a sense of 'empowerment' in which support is provided for the capacity of choice (i.e. the choice to enjoy an opportunity to exercise some capability or not). When somebody talks about respecting a person's dignity in this liberal sense, he aims to highlight that person's right to choose freely in practicing any of their capabilities. Hence, liberal dignity is a providing and supportive concept. There are many examples of this sense of dignity particularly in international human rights instruments. For instance, in article 22 of The Universal Declaration of Human Rights (UN 1948) we read:

> Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co–operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Here, the writers of this Declaration use dignity in a supportive sense to ground a range of human rights (namely; economic, social and cultural rights). This is an example of the liberal sense of dignity which underscore the rights of dignity possessors to have opportunities and to freely decide to practice their capabilities. However, the concept of dignity does not always serve human beings by supporting them in line with the liberal conception; it sometimes causes restriction and 'constrains' people - particularly by putting limitations on the right of free individual choice. The concept of dignity in this sense is used to underscore cases in which respecting people would entail limiting their individual choices. To respect dignity in this *conservative* sense others (or even oneself) should be restricted from doing something freely.

Obviously, restrictions imposed on human freedom in this way are based on the importance of allowing for the flourishing of the basic capabilities of others. For example, dignity can be employed to restrict one from practicing cruelty in order to support the capabilities of others (e.g. the capability of bodily health, bodily integrity, affiliation) which otherwise might be harmed. However, the point of distinguishing liberal from conservative understandings of dignity is to show that in each case the aim of using these concepts can be different:

> As empowerment [in the liberal function], human dignity is equated with the capacity to choose, giving rise to a human rights regime that promotes individual autonomy. As constraint [in the conservative function], human dignity limits the free choice of individuals to actions that are compatible with respect for the human dignity of others

[50] For further discussion see Beyleveld & Brownsword (2001); and also Brownsword (2014). The terms used in this section are inspired by these references.

and of oneself (Chan 2015 :277).

One of the famous examples of the conservative sense of dignity is the case of 'dwarf–throwing' that caused controversy in France in 1995 (cf. Beyleveld, Brownsword 2001: 26)[51]. The Conseil d'Ét̂at ordered the police to prohibit any form of display that is against human dignity. Following this, the police banned the attraction of 'dwarf–throwing' in local bars. Although some of the people of short stature claimed that they freely chose to participate in these events and that they would be made unemployed by the banning of 'dwarf–throwing', the Conseil maintained that these activities were instances of considering human beings as mere objects and, therefore, should be prohibited even if the dignity bearers (i.e. people of short stature) freely chose to engage in it. In this case, employing a conservative conception of dignity led the Conseil to restrict rather than protect the free choices of people of short stature (and of others in favour of continuing the practice).

The liberal sense of dignity is usually involved in cases with an individualistic orientation, in which the idea of dignity is supposed to empower the individuals' rights, as in the Universal Declaration of Human Rights. The concept of human dignity in its conservative sense, in contrast, can be found mostly in cases when the state or some other body intends to prohibit certain actions which are against human dignity, such as restrictions defined in bioethical documents for medical teams and researchers in order to protect people from any failure to respect dignity.

For example, UNESCO forbids the reproductive cloning of human beings in article 11 of the Universal Declaration on the Human Genome and Human Rights (UNESCO, 1997). In this example, as well as in many similar cases, the concept of dignity is used to highlight a kind of restriction over persons. In brief, dignity sometimes has a liberal sense which supports the development and exercise of opportunities and freedom. It can also have a conservative sense, in which freedom can be restricted in order to respect and protect dignity.

Returning to Nussbaum's position concerning bad capabilities, as mentioned above, she states that bad capabilities should be inhibited. Inhabiting a capability, however, is not merely not supporting that capability, it also concerns deterring human beings from exercising those capabilities. This is compatible with the conservative sense of human dignity. Therefore, despite a generally liberal approach, Nussbaum also points to conservative considerations. However, what is not clear in Nussbaum's approach is the way in which she applies these conservative aspects of her theory.

[51] For more examples of conservative dignity see Brownsword (2014: 12).

I can imagine two ways in which Nussbaum could deal with bad capabilities. One way of considering bad capabilities would be to provide a list of important bad capabilities (in parallel with the list of important good capabilities). Moral agents would then have two kinds of duty: to support the list of good capabilities and to deter the exercising of bad capabilities. This gives the idea of two kinds of respect: positive and negative.

To respect the dignity of people (rights–bearers), sometimes something should be done for them. For instance, to give patients the opportunity to be with their family a designer may provide single–bed rooms with the provision of accommodation for patients' relatives. In this form of respect, then, the designer has helped to enable something for the patients (i.e. being with their family), which I call *positive respect*. In contrast, there is another form of respect concerning the rights people have to be protected from something happening to them, which I will call *negative respect*[52]. For example, a designer who provides for a private room for patients in order to protect them from public–viewing has respected their dignity in this negative sense.

Nussbaum, however, has not provided two lists of capabilities, even though she discusses the importance of considering both 'affirmative tasks' as well as 'negative rights' in the public sphere (Nussbaum 2006: 291). In some cases, Nussbaum makes points at odds with her liberal approach. The capability of cruelty is an example which was mentioned already. Nussbaum also prohibits public humiliation (Nussbaum 2008: 370). Other prohibited acts can be suggested in this way so that a list of bad capabilities can be compiled.

However, Nussbaum seems to take the other strategy: she incorporates the ways in which a capability might be harmed within the definition of that capability and suggests that we prevent the dignity-bearer from suffering such harms. For example, in the definition of the capability of 'bodily integrity', as shown above, she calls for securing people "against violent assault, including sexual assault and domestic violence". By adding protective measures, Nussbaum tries to save the dignity-bearer from the harm of bad capabilities practised by others. Instead of having a list of bad capabilities she chooses to point out the ways in which a capability might be harmed. There is an important difference between these two strategies.

In the former strategy, moral agents act directly towards the capability possessor in order to deter her from experiencing that capability (such as the capability of cruelty). However, by putting protective measures in the list of human entitlements, the focus shifts from the capability-possessor to the dignity possessor. In other words, the practicing of bad capabilities

[52] Compare the distinction between positive and negative rights.

per se is not prevented, unless it harms the rights-bearer. Given that a rights-bearer is free to enjoy her entitlements, this implies that if she does not want to enjoy any of her entitlements (e.g. she does not want to be secured from assault), an agent may be permitted to practice bad capabilities against the rights-bearer (i.e. to assault the rights-bearer). Nussbaum, for instance, sees no reason to prevent private humiliating relationships (Nussbaum 2008: 370).

This strategy of Nussbaum's is truly in line with her liberal thoughts. However, when considering conflicts between human dignity and human freedom, we might expect to see Nussbaum on the dignity side given that she selected dignity as the basic notion of her theory. But it seems, at least from a non-liberal point of view, that in this way she sacrifices her opinions about human dignity and the decent life in order to save her liberal ideas: 'being humiliated' is one of the oft-remarked examples of the conditions which are against the dignity of human beings.

These are grounds for me to be wary of accepting her theory as a general theory of justice (i.e. these deficiencies would need to be addressed first). Nonetheless, it is worth noting that this problem does not undermine the privilege of this theory in the field of hospital design. This is because the hospital environment is not an active agent that can directly commit bad capabilities. The hospital environment is a facility which is essentially in the service of capabilities: facilities give the *opportunity* to act for certain purposes, rather than impelling such enactment. It will be up to the users of hospitals to take advantage of those facilities or, alternatively, to refrain from using them. Therefore, the second strategy taken by Nussbaum, in which protective measures are inserted into the list of basic entitlements, is compatible with the context of the hospital environment and its design.

3.1.3.5. Capabilities Intertwined with Dignity

In addition to the way in which Nussbaum considers bad capabilities in her theory, there are also some difficulties in her linking of the notions of dignity, capabilities, and entitlements. As was mentioned earlier, the list of capabilities is inspired by the idea of human dignity and a dignified life. In this light, Nussbaum believes that the basic capabilities of human beings are intertwined with the dignity of human beings (Nussbaum 2006: 162). However, when Nussbaum starts to address the capabilities in more detail, some difficulties appear.

As explained above, Nussbaum insists that we focus on capabilities rather than functioning, in order to have a more general approach that can be accepted by people from different doctrines and religions. She mentions the capability of voting or the capability of religious practice, in

this regard. Some people are religious and some are not, but an atheist can accept the inclusion of religious practice in the list of entitlements as this does not entail that citizens are obliged to pray (i.e. it is not about functioning). Similarly, a "member of the Old Order Amish will not vote or participate in politics, but he or she can accept the *right* to vote as a fundamental entitlement of all citizens" (Nussbaum 2008: 361, emphasis in original).

However, if we put 'voting' in the list of capabilities then this seems to imply that providing for such an opportunity is part of what it is to respect the dignity of a person. To reply, Nussbaum points out that the followers of the Capabilities Approach should think in a pluralistic way, in which one respects the choice of others even if one believes that choice to be wrong (e.g. for the Old Order Amish it is wrong to vote, similarly for an atheist it is wrong to worship God) (Nussbaum 2006: 182-183). I do not find this answer satisfactory. A pluralist atheist, for instance, may respect the choice of a religious person, but this does not necessarily mean that such a choice is viewed as "intertwined" with human dignity. There is difference between accepting the list as the main entitlements of human beings and accepting the list as indicators of human values. It is valuable to respect the choice of others even if it is not in line with one's own beliefs; but it cannot be expected that the reason for such a choice will also be accepted as something valuable.

I think this difficulty disappears when we move from considering Nussbaum's list as a list of 'capabilities' to considering it as a list of 'entitlements'. As a list of entitlements, we can incorporate elements that are related to the freedom of human beings, and we can hope to reach an overlapping consensus. For example, even those who do not consider voting as something valuable can agree to have the right to vote in the list as an entitlement. Accepting such a right does not mean that they value voting, but rather means they value the *right* to vote.

However, if we consider the list as a list of capabilities and incorporate voting (or worshiping, etc.) into the list as part of the central human capabilities, this would imply that everybody should accept voting as something valuable, given that Nussbaum has already said that capabilities are intertwined with dignity. In general, someone who accepts the right to vote (i.e. when considering the list as a list of entitlements), may not accept it as a valuable thing (i.e. when considering the list as a list of capabilities). Therefore, while there is good reason to hope for an overlapping consensus when considering the list as a list of entitlements, this is not the case when considering it as a list of capabilities wherein some items are included that one group of people value and others do not (e.g. voting).

However, as Nussbaum mentioned, this is *her* list of capabilities and it is subject to change. Hence, one way to address this difficulty is to improve upon the list in a more general way so

as to avoid these kinds of problems. Also, the aforementioned difficulty will be alleviated when the list of capabilities is brought into a specific society or field, in which there is less disagreement about such issues. As was mentioned above, Nussbaum designs her list in a general way in order to include the doctrines of a wide range of societies with different perspectives. She explains that this list can be further specified when it is introduced into a specific society by considering such a society's own particular values and beliefs. With more specification, and by incorporating the domestic values and beliefs into the definitions of the capabilities, fewer problems will occur (our assessments concerning a 'decent life' – i.e. dignity as decency, and not as value – is, at least partly, dependant on a specific social context).

This problem can be further weakened if we see the suggested list as a list of entitlements, rather than capabilities. As argued above, the aforementioned challenge is highlighted when we want to link the content of the list to what people take to be of value. But, in the context of human *rights* people with different perspectives can adopt the same basic entitlements. Therefore, one way of modifying the content of the list is to focus on the language of human rights rather than human capabilities. This can occur if we consider, for example, the headings of each capability in the list (e.g. affiliation, bodily integrity, etc.) as the list of capabilities (which are intertwined with human dignity and, owing to their generality, can aid in reaching an overlapping consensus on them); and consider the description of each capability as the list of entitlements (e.g. protecting the freedom of assembly and political speech, to have adequate shelter, etc.)[53].

All in all, Nussbaum's list of entitlements provides a suitable platform to apply ethical considerations in terms of the hospital environment. The main concern of this list is human capabilities; the conditions in which human beings are entitled to flourish. This notion is particularly important in hospitals. People in hospitals cannot exercise their capabilities in many respects: patients face physical and mental disabilities and pressure, medical staff have demanding and stressful jobs; relatives experience stressful concern for their hospitalised family members; and so on. Almost every person in a given hospital faces conditions that to some degree hamper them in the pursuit of their interests and activities.

In the Capabilities Approach, we hate such conditions, believe that we all have a correlative responsibility to support for the capabilities of human beings in order to empower them to live

[53] In this thesis, I will consider the list of capabilities in this sense; that is to see the descriptions of each capability as the list of human entitlements. In this way, the descriptions of what I will render as a compatible list of capabilities in hospital environment should be considered as the list of entitlements of people from the hospital environment.

more normally, to live a life worthy of human dignity. The fundamental theme of the Capabilities Approach, in which human beings are seen as *vulnerable* and deeply dependent on the external world, is tailor-made for what I suppose to be the responsibility of hospital designers. Now, after defining the main entitlements of human beings, it is appropriate to talk about Nussbaum's views on duty-bearers.

3.1.4. Responsibilities

3.1.4.1. Vulnerable People in Hospitals

The vulnerability of human beings is essential and valued in the Capabilities Approach. This character of the Capabilities Approach is particularly inspiring in the area of hospital design. To explain more: as I have mentioned[54], people not only have a duty to respect the dignity of others, but they also have a duty to respect the dignity of themselves. To interpret this in terms of Nussbaum's approach: people have an ethical duty to provide for their own capabilities, and to protect themselves from those conditions which are below the thresholds of living with dignity. For example, if a dignity possessor is sick and wants to protect his bodily health capability, he has a responsibility to visit a doctor. Similarly, we have an ethical duty to provide for all of our capabilities when we want to exercise, develop or protect them. This is normally how we act.

To greater and lesser extents, people respect their own dignity and they usually attempt to protect it from being mistreated by others (i.e. from going below the thresholds). People respect and protect their own dignity, although they may not generally do this under the description of 'respecting their own dignity' - much less 'following the specifics of Nussbaum's capability theory'. In common life, we actively protect ourselves from situations in which we feel degraded or humiliated, for example, by keeping ourselves away from situations in which others may fail to respect our dignity. It may be true that the first person to respect one's dignity is oneself. However, if one wants to respect one's own dignity, it is necessary to have sufficient ability to do so and consciousness of one's situation.

For instance, people usually seek shelter in a private area when they need privacy. This is an ability that a patient after a surgery may lack because he still cannot move, or may even be

[54] See section 2.3.2.2.

unconscious. If he was able to move or understand his situation, he would probably strive to go to a private room when he finds himself in an inappropriate condition and environment (e.g. without decent clothes or being in a mixed–sex bay). Since he does not have the ability to protect himself from degradation, he is vulnerable and needs others to make up for his disability by placing him in a private or segregated room.

Consequently, the dignity-possessor's attempts to respect and protect his own dignity play a major role in his life, *provided that* he is capable of such actions. In many cases, if one respects oneself, nothing would remain for others to do. For example, a person who can go to the hospital when he is sick is already able to respect himself in these terms, and other people do not need to bring him to the hospital. However, if the dignity-possessor is not able to respect his own dignity, this responsibility would shift to others. In these cases, such as when a sick person needs others to carry him to a hospital, other people have to make up for the dignity-possessor's disability and do more for him than in those cases in which the dignity-possessor is able to respect himself.

In many situations, hospital users cannot respect their own dignity properly and, therefore, this duty shifts to the other stakeholders in the hospital. Patients in hospitals are at the centre of this problem. Patients may endure enormous stress and pain; they may have anxiety about their future and their life; they may lose consciousness and become unaware of their surroundings; they may lose their normal abilities due to their illness; and there are many other situations and conditions for patients which may affect their ability to exercise or protect their capabilities on their own. Patients' relatives are also in special conditions in hospitals. They probably endure stress for their family member, particularly if their family member faces a serious problem. Their situation could be made worse if they are unable to see their family member or obtain updated information about them.

In such stressful conditions, families are perhaps unable to concentrate sufficiently on their own dignity and therefore might not respect their own dignity properly (e.g. by not resting sufficiently, not sleeping well, not eating enough and the like). Although the stressful condition of families and their concern for their hospitalised family-member may cause them to not respect their own dignity sufficiently, being in an unsuitably designed hospital can make this even worse. For example, if the hospital does not have enough amenities such as a buffet for eating, or even chairs for resting, relatives may prefer to stay near to their hospitalised family-member and endure the tiredness or hunger rather than going outside of the hospital premises to find something to eat, or somewhere to rest.

Insufficient consideration of one's own dignity can also be a problem for staff. Medical teams

are working in a stressful and sensitive job in which a small mistake may cost the life of their patient. Furthermore, they may witness the screams of patients in pain which need to be tolerated, the grief of families which need to be met with compassion and many other demanding conditions. Faced with such emotional environments, the respect they owe to their own dignity may lose its priority and the hospital staff's efforts may tend to be for others rather than themselves.

In short, there is a danger of patients and to some extent their relatives as well as hospital staff, losing sight of their own dignity. As I explained above, in such cases in which a person loses his ability or capability to respect his own dignity, additional ethical responsibilities would shift to others in order to provide for those capabilities. Returning to the point mentioned a couple of paragraphs ago, respecting the dignity of others in hospitals becomes a crucial matter because of the high level of risk for people who can be in situations in which they cannot respect their own dignity. Correspondingly, this would create further responsibilities for others, who can play a role in supporting people in hospitals. In this regard, a hospital designer, for instance, should not think that he has met his duty if he provides an environment in which medical teams can easily deliver their professional commitments. As people lose their ability to respect their own dignity, the hospital designer should provide a suitable environment in which other people can meet their extra responsibilities. Now, the question is: what can the hospital environment provide in this respect?

Human beings have an ethical responsibility to support each other in hospital. In order to meet such duties, we need sufficient materials, opportunities, and facilities. The role of the hospital environment appears in this step. The hospital is a facility to help medical staff treat patients. For this purpose, hospital constructors endeavour to prepare all the facilities needed for treating patients in hospitals. This is the usual approach of hospital designers in their job. However, the hospital environment should not only be in the service of the bodily health capability. The list of basic entitlements suggests that we think about a range of capabilities which should be supported, all of which have the same value and importance as the bodily health capability. For example, a hospitalised patient may not be able to adjust the heat of his room, in the same way that he could do when he was healthy in his own house; and, in this way, he may lose his sense of control over his surrounding environment (the tenth capability in Nussbaum's list). However, an appropriate hospital environment might provide a remote control by which the patient can set for a convenient degree of heat or cold from his bed. Therefore, a supportive hospital environment facilitates the practicing of *all* the central capabilities.

It should also be noted that respect for the dignity of patients can be direct or indirect. In order

to respect the dignity of a human being, in many cases, a moral agent may *directly* perform something towards the dignity-bearer. However, sometimes we should perform something towards another person (or other people), in order to provide an opportunity by which the person (or people) can respect the dignity-bearer (i.e. *indirect respect*). For example, when a designer provides a private room for patients, he respects the dignity of the patients *directly;* but when he designs a proper environment for treatment, he has respected the dignity of patients indirectly. This is because such an environment gives an opportunity to the medical team so that *they* can enhance the capabilities of the patient.

Therefore, in order to respect the dignity of a person whose capabilities are (in danger of) falling below the thresholds, it is not always necessary that we are able to provide for those capabilities directly ourselves. If we can provide for or encourage others who can support those capabilities, we are respecting the dignity of that person, too. Thus, the hospital environment can support the capabilities of patients either by providing a condition or opportunities which can make up for the disabilities of patients (e.g. the example of the remote control for the patient's room), or by providing a proper condition which makes supporting possible (e.g. designing a suitable room for a confidential conversation between a patient and her physician).

Therefore, a properly designed hospital environment not only eases the process of care, but also facilitates the condition in which a patient can practice his own interests and capabilities. For this purpose, two central factors are needed: first we need to determine the basic entitlements of people in hospitals. Determining such entitlements, it will become clear which capabilities need to be supported in order to enable people to have a life commensurate with human dignity. I will pursue this aim in this chapter. In addition, designers need to know in which ways people may be harmed in hospitals so that they can take the appropriate elements and forms of design in their planning by which the risk of harm is reduced. In the next chapter, I will suggest three ethical principles for hospital designers which can highlight the ways that the level of human capabilities may become lower than the thresholds; and accordingly, the designers will be able to identify how to provide for those risky areas.

3.1.4.2. Institutions

As I said in the Kantian section, any right arising from human dignity implicitly defines people's responsibilities towards those rights. Thus, the list of basic entitlements actually highlighted the corresponding *responsibilities* of people towards each other. In the Capabilities Approach, the responsibility we owe to other people (i.e. to respect others) is to support each

other to secure, at least, the minimum level of these entitlements. Since Nussbaum's language in the Capabilities Approach gives precision to and supplements to the language of human rights (Nussbaum 2006: 284), it is able to describe people's obligations with practical criteria. This ability is suitable for studies that wish to use the concept of dignity in a practical context, such as this research (in comparison with Kantian dignity which is based on the abstract idea of the autonomy of the will).

Since Nussbaum's basic theme in her Capabilities Approach is to address social justice, she tries to take a more practical position in order to clarify how the Capabilities Approach can handle different related issues. For example, she develops her ideas towards animal rights and the corresponding responsibilities. Likewise, she expands her theory on the issues related to global justice. In terms of a just society, she particularly focuses on the responsibilities of *institutions* to citizens in providing for their basic entitlements. This aspect of Nussbaum's argument is considerable for the purposes of this research and I will discuss it shortly.

As was mentioned above, according to Kantian dignity human beings have ethical responsibilities towards each other. Nussbaum has the same idea; she believes that we all have collective ethical responsibilities in providing and supporting for human capabilities (Nussbaum 2006: 280). This responsibility is to secure the ten basic human entitlements at least to the thresholds level. Hence, the main concern of Nussbaum is to identify how people can be rescued from being *beneath* the thresholds. In this regard, she sees the role of *institutions* as essential. Nussbaum states that one of the purposes of social cooperation is to guarantee the basic entitlements of human beings by establishing principles and institutions (Nussbaum 2006: 274). Although it is ultimately human beings who should deliver their duties towards people's rights, Nussbaum counts four reasons to consider the crucial role of institutions (Nussbaum 2006: 307-309).

The first one is the fact that some human entitlements cannot be addressed individually, and need an institutional structure for their security (e.g. systems of property rights, or criminal justice). The second reason concerns fairness: without institutions and systems, one may pay a lot to enhance the level of capabilities of others up to the thresholds, while the others may not meet their responsibilities. This is not fair and may end up impoverishing the moral agent. Moreover, institutions have the causal power to handle some problems which are less likely to be dealt with by individuals, such as global warming. And finally, if an individual extensively attempts to provide for others, she may lose the sense of her own life (e.g. her personal integrity, her agency, her friendship and family).

By having the list of entitlements, and depending on which issue needs addressing, the relevant

responsible parties and institutions will be clear (Nussbaum 2006: 311). Nussbaum's approach towards the importance of institutions in addressing the entitlements of human beings is vital in the context of ethical hospital environments. Inspired by this approach, and by having a specified list of people's entitlements in hospitals, we can identify the ethical obligations of stakeholders.

Thus, even though Nussbaum develops her theory in the context of social justice, the same approach can be taken in this field, namely ethical hospital environment. Moreover, providing an ethical medical environment can be seen as part of the requirements of a just society, in which the dignity of people is essential. Therefore, the findings of her theory cannot be seen as entirely detached from the ethical concerns of my research. However, we need to be more specific when bringing Nussbaum's thoughts into the context of the hospital environment.

As was mentioned earlier[55], there are many parties who have a role (directly or indirectly) in shaping the hospital environment. From (perhaps) parliament, which dictates the general amount of funding needed to construct, rebuild, or maintain the hospitals of a nation, to engineers and architects who construct hospitals, to hospital managers and others who use the hospital environment to deliver their service to people. In providing a suitable hospital for people which fully supports the entitlements of patients and others, we need to identify the responsible parties for each aspect of the hospital. Therefore, after we specify the entitlements of human beings in terms of the hospital environment, we need to identify the responsibilities of both institutions and individuals (particularly individuals working as 'professionals' - such as architects, engineers, interior designers and the like).

Obviously, the kind of responsibilities of each party will differ accordingly. For example, we expect the healthcare organisations of a country (e.g. the NHS) to define and control sets of regulations and standards which are needed in order to ensure a suitably designed hospital. Correspondingly, the responsibilities of architects, for instance, would be to design according to the general requirements of a hospital alongside the specific requirements of that hospital. In addition to the defined obligations by institutions, professionals also need to consider their own particular responsibilities related to their specific job. A hospital manager, for instance, may find some ethical requirements of people which had not been predicted in regulations, and thus, have not been provided for. Therefore, in addition to informing the relevant people of the need for a change in the hospital's standards, she may strive to arrange the available spaces in the hospital in such a way so as to minimise the potential harm of such an

[55] See section 3.1.3.1.

environmental deficiency.

For example, if there were no suggestion in the standards of hospital design to provide for the communication between a patient and her relatives, architects may fail (or forget) to consider such spaces in the hospital. Practically finding such deficiency, the hospital manager may ask an interior designer to see how they can re-design some areas of the hospital so as to provide for a suitable environment for communication.

All in all, according to Nussbaum's Capabilities Approach we have collective responsibilities to provide ethical hospital environments. In the context of hospital design, the responsible parties can (mainly) be found among the relevant institutions as well as professionals. In this light, I am going to consider how the concept of dignity is seen among those who have a role in shaping the hospital environment. I will then consider how a tailor-made list of the environmental entitlements of human beings can enhance our understanding of the corresponding responsibilities towards hospital users.

The list of the environmental entitlements of human beings in hospitals illustrates the corresponding responsibilities of hospital designers. Having such a list, hospital designers would be responsible for designing a hospital environment wherein the practice of human capabilities is facilitated. In the next chapter, I will focus specifically on the responsibilities of hospital designers. As a facility, the hospital environment can positively or negatively affect the ability of its users. In this regard, designers need some principles which highlight the main ways in which the capabilities of people may be harmed in hospitals. Such principles can be considered as the main ethical principles by which designers can provide for the capabilities of hospital users. However, before I start to explore the implications of the Capabilities Approach in hospitals, it is worth investigating how the other important implication of human dignity (i.e. equality) is considered in Nussbaum's theory.

3.1.5. Equality

3.1.5.1. Equal Dignity of Hospital Users

Similar to Kant, Nussbaum believes in *equal respect* for all citizens (Nussbaum 2006: 207): human beings are equal in their value and, therefore, should be equally respected. In the Capabilities Approach, this indicates that all human beings are *equally* entitled to enjoy a

condition in which their capabilities are empowered at least to the threshold level. In such entitlements, there is no difference between human beings. As far as a person cannot practice one of her basic capabilities, she is entitled to be sufficiently supported.

Bringing this point into the context of the hospital environment, a suitably designed hospital is one wherein those whose capability levels are beneath the thresholds are equally entitled to support. Obviously, patients are the main target of such an environment. This is because they are seemingly more vulnerable than others, and need the help of others to regain their normal conditions. However, the fact is that almost everybody in a hospital is at risk of losing their ability to secure, or their concentration on, their dignity and entitlements. Since all human beings are equal in their rights, the hospital environment should not solely enhance the capabilities of patients; it should also be supportive for all other human beings in hospitals who are (in danger of) falling below the thresholds in any of their capabilities.

Accordingly, a moral designer should take the capabilities of all hospital users into account, and try to discover how their capabilities may be harmed in the hospital environment. For example, a designer should notice that doctors and nurses have difficult and stressful jobs. Thus, they need a suitable area in which they can rest for a while so that they can be refreshed and ready to continue their work. Similarly, the mother of a sick child may desire to stay with her child in hospital. A hospital designer should then predict the need for an appropriate environment for mothers in children hospitals so that they can remain with their child.

All in all, what should matter for a designer is the need to enhance (or protect) the level of people's capabilities which may be (or become) beneath the thresholds. In this regard, *all of those who use the hospital environment* should be counted. Of course, patients in hospitals are expected to be more vulnerable than other parties and, accordingly, they need more consideration. However, this fact does not undermine the importance of supporting the other human beings in hospitals. Up until now, I have been talking about the dignity and rights of patients in hospitals. Having explained the equal importance of the dignity of all human beings, I will from now on concentrate on the capabilities of everybody in the hospital environment. Consequently, the ethical principles defined in the next chapter target the dignity of all hospital users.

3.1.5.2. Equality in Adequacy

As a theorist of social justice, what is essential for Nussbaum is not the bare concept of dignity, but rather *equal* dignity:

> Equality of capability is an essential social goal where its absence would be connected with a deficit in dignity and self-respect. We have seen the idea of dignity is spelled out from the beginning in terms of equality: it is the *equal dignity* of human beings that demands recognition. Here the idea of equality is essential: we must add it to the bare idea of dignity in order to articulate the goal in an adequate way (Nussbaum 2006: 292, emphasis is in original).

However, Nussbaum faces a challenge that she tries to handle: on the one hand, as quoted above, her emphasis is on 'equal' dignity. She also insists that capabilities are intertwined with dignity. Accordingly, we can infer that the sense of equality should be applicable to all capabilities. On the other hand, however, it does not seem correct to claim that we have a responsibility to equally provide for all entitlements. Nussbaum divides capabilities into two categories. For some capabilities such as "political, religious, and civil liberties" equality is applicable: discrimination in these capabilities would be against a dignified life. But for some other capabilities (mostly those which are related to property and instrumental goods), it seems that human dignity only conveys a sense of "enough" rather than equality (e.g. providing a threshold of adequate housing or shelter, rather than equal housing) [56].

The problem that I find in Nussbaum's arguments is that it seems as though she thinks that in order to justify this sense of adequacy she has to deny the "intrinsic relationship" between some capabilities and dignity (Nussbaum 2006: 382); a claim which is contrary to her previous position – i.e. that capabilities are intertwined with dignity (Nussbaum 2006: 162). Nussbaum holds that the concept of dignity is important when the notion of equal respect[57] is relevant. In this regard, Nussbaum claims that the conception of equality is pertinent to cases related to non-humiliation and reciprocity (Nussbaum 2006: 382). In my view, this explanation not only fails to address the main question mentioned above (i.e. denying the intrinsic relationship between dignity and some capabilities yet emphasising that dignity is intertwined with capabilities), it is also not even correct.

For example, segregation is one of the essential patient's entitlements which is related to rights

[56] There are many arguments in the literature concerned with the concept of 'adequacy' and 'sufficiency' and the way they should be applied in the Capabilities Approach, which we do not have enough space in this thesis to explore. For more arguments see, for example, Nielsen & Axelsen (2017), Schuppert (2014), Ram-Tiktin (2011). In this section, I will only address Nussbaum's own arguments.

[57] The notion of respect for human beings Nussbaum uses in this case, however, does not have the same sense of Kantian dignity (as the responsibility of human beings towards others) in this case; it rather should be equated with the concept of honour: to honour human beings.

concerning non-humiliation. However, for this requirement, we seek an 'adequate' condition of segregation, rather than an 'equal' condition. Overall, I think, Nussbaum does not properly explain the relation between dignity, equality, and adequacy. Still, I think this challenge can be addressed within the framework of Nussbaum's Capabilities Approach by considering some vital points.

It seems that Nussbaum needs to clarify the two distinct senses of dignity as value and dignity as decency[58]. When we are generally talking about the value of human beings it is similar to the Kantian meaning of dignity. In this sense human beings are equally valuable; this is the sense of dignity which Nussbaum *begins* her theory with. In Nussbaum's account of dignity, as mentioned before, human beings have value (i.e. dignity) because of their capacities to flourish and engage in various activities. Accordingly, when Nussbaum is addressing the general conception of human flourishing she is mostly concerned with human value. The equality of human beings is applicable in this sense, as it similarly is for Kantian dignity.

However, when Nussbaum intends to highlight human entitlements and a decent life, she mostly refers to the conception of dignity as decency. This sense of dignity deals with the quality of life. Arguments about the application of equality and adequacy are mostly related to this area (i.e. dignity as decency). The concept of dignity as value considers the value and relations between human beings, in which the concept of equality indicates that all human beings have the same and equal value. The concept of dignity as decency mainly refers to the entitlements of each individual and, therefore, what matters are the adequate goods and opportunities of *an individual*.

The concept of equality in the notion of dignity as decency, thus, is not about the equal value of human beings (even though it is rooted in that sense). Equality in capabilities, in this sense, rather refers to those aspects of capabilities that are related to other people, such as equality in defining the thresholds of the capabilities. In this light, for dignity as decency we need both concepts of 'equality' and 'adequacy' for all capabilities.

On the one hand, there is no need to limit the concept of thresholds to only certain entitlements (e.g. housing and shelter). The whole idea of the Capabilities Approach is that there are certain central entitlements that everybody should be able to enjoy, at least up to a minimum level (i.e. thresholds of capabilities), in order to have a life with dignity. Therefore, since we determine such thresholds (i.e. minimum levels) for all capabilities, we have already accepted

[58] To read discussions of the distinction between dignity as value and decency, see section 2.5.5 and 2.5.7.

a sense of adequacy for all capabilities. In terms of freedom of speech, for example, which in Nussbaum's view should be classified in the group of equality-applicable capabilities, we still need to determine an adequate level of access to the media or other tools so as to ensure that everybody is heard, for instance.

On the other hand, however, the concept of equality should be applied to *all* capabilities. As was said above, we need to determine an adequate level for each capability. We should also bear in mind that the Capabilities Approach is mainly about providing opportunities and giving the chance to people to practice and flourish in their capabilities. Respecting equal dignity, then, requires that everybody should be able to enjoy a minimum level of those opportunities *equally*. This means that people have an equal right to be provided for and to be supported up to the 'adequate' (i.e. minimum) level of each capability. Respecting dignity on the basis of its being equal, hence, does not necessarily mean that equality for all capabilities should be the goal of a society; rather there should be equal provision for the 'adequate' level of opportunities for each capability.

Therefore, in my opinion, equality can function as a condition for determining the thresholds of capabilities: we can adjust the level of thresholds according to the idea of giving equal opportunities to all people. For example, Nussbaum, in the case of education, states that "precisely where the line should go as to the level of education that should be provided free of charge by the state may vary somewhat in accordance with the type of economy and employment in a state, although the level should not vary as much as levels do in reality" (Nussbaum 2006: 180). In this instance, Nussbaum predicts that the economy and the type of employment may determine where the thresholds should be. However, in my point of view, if it is the economy (or any other factors) which is to determine the minimum level then the role of 'equality' is to suggest that such a level should be considered in a way that can provide an *equal* opportunity for education for all members of that society. This is what I meant by *equality in adequacy* in the title of this section.

It should also be noted that Nussbaum's Capabilities Approach does not have any suggestion for the sense of equality above the thresholds of capabilities:

> Up until now, however, the approach has insisted only on idea of adequacy or sufficiency, and has stated that the question of what to do with inequalities above this minimum threshold is a further question that the approach has not yet answered (Nussbaum 2006: 292).

It is also important to note that in the concept of 'equality in adequacy', the term of equality does not necessarily refer to a quantitative equality; it can also be considered as a qualitative

equality. What is emphasised in Nussbaum's theory is the need to identify a level of ability which represents a decent life for human beings (dignity as decency). However, saying that people are equally entitled to have a decent house, for example, does not necessarily mean that they should all have an equally sized house.

The spaces and facilities a disabled person needs in her house might be different from the needs of an athlete. Similarly, we should remember that when we are talking about the need for private areas in hospitals, in a general sense, this means that all people who stay in hospitals have a need for such spaces. But in specific cases, it is essential to consider that in NICU, for example, this private area should be defined as a space for a mother who sits next to the incubator of her child, which is very different from the privacy in a mental hospital, for example.

The above explanation illustrates the importance of the concept of 'thresholds' and 'adequacy' in the context of hospital environment and design. This is because a hospital is a facility and its main purpose is to provide adequate (and not necessarily equal) tools and appropriate conditions in which medical teams can treat their patients. As Ram-Tiktin states: "a just distribution of goods [e.g. medical care resources] is one that assures that everyone attains the sufficiency threshold of basic human functional capabilities, to the extent possible" (Ram-Tiktin 2011 :24). Therefore, what is essential in hospitals is to have appropriately designed environments which *adequately* facilitate the healthcare service. In the next chapter, I will explain how the concept of thresholds can help me to define the ethical principles for hospital design.

3.2. Why the Capabilities Approach?

Thus far, I have attempted to elaborate on the concept of human dignity and its implications through Nussbaum's Capabilities Approach; a theory that I think can lead us to identify an ethical approach to hospital design. Among my arguments concerning the Capabilities Approach in both the current and previous chapters, I mentioned the advantages of the Capabilities Approach for the purposes of this thesis. Here, I would like to render a summary of those advantages which caused me to select this theory as the leading idea in identifying the ethical method of hospital design.

3.2.1. The Value of Flourishing and the Vulnerability of Humans

The main reason for choosing the Capabilities Approach is related to the main theme of this theory. As mentioned before, Kantian dignity places value on rationality: the characteristic of human beings which cannot be affected by external causes. This idea cannot inspire hospital designers who are providing an environment for people with extreme vulnerability and dependency on others. In contrast, Nussbaum's Aristotelian-Marxian conception of dignity is in the same direction which a moral designer needs. Firstly, it emphasises that what is valuable in human beings are their capabilities to flourish. As a result, to respect the dignity of human beings we need to provide conditions in which they can pursue their interests and striving activities.

Secondly, it insists that human beings have an embodied nature and a range of stages in their life from weakness to strength, and then vice versa (i.e. beginning as a baby, then becoming an adult, and finally - if sufficiently lucky - becoming old). In some of these stages we are more vulnerable than in others; however, in all of these stages humans, as social beings, need others to shape their sense of life, a life which should be compatible with the dignity of human beings. People in hospitals, and particularly patients, are vulnerable and this means that their capabilities need to be developed or at least protected. This is exactly what hospital designers should consider in their designing and this is exactly what the Capabilities Approach asks one to do. What we expect from a moral designer is that they create a hospital environment in such a way so as to ensure that support for the capabilities of people is sufficiently facilitated. Hospitals as facilities can undoubtedly play a key role in providing for the support of people in hospitals. Consequently, the general theme of the Capabilities Approach is in the service of a moral design.

3.2.2. Dignity as Decency

In addition to the Kantian meaning of dignity as value, as mentioned before, the concept of human dignity for Nussbaum has another meaning. In this meaning, dignity highlights a sense of a 'decent life'. Although Nussbaum herself does not explain this meaning of dignity, she links the term of dignity to a minimum quality of a dignified life. This conception of dignity can help to bring an abstract Kantian sense of dignity as value to the more concrete notion of a 'decent life'. The concept of a decent life highlights the importance of the quality of human life, which is a more inspiring general idea for designers, rather than merely saying that human beings have valuable status. This idea is completed by Nussbaum in her providing a list of entitlements which can be considered as a description of a 'decent life'. Overall, utilising the concept of dignity with the conception of a 'decent life' makes her account of dignity more

motivating for designers than the abstract Kantian sense of dignity as value.

3.2.3. A Non-Metaphysical Sense of Dignity

I hope that what I will suggest as the ethical method of design will be acceptable for the majority of designers. I need to establish the foundation of this method on a notion which is accepted by people from various perspectives and backgrounds. The concept of human dignity is the basis of the Capabilities Approach. I think the concept of dignity has such a capacity. This can be seen in the broad references to human dignity in the international and regional declarations and conventions, as well as national legal systems. The International Declaration of Human Rights (UN 1948) as a milestone document is an example of the universal concern for dignity. The Preamble of the Declaration, for instance, emphasises inherent dignity as one of "the foundations of freedom, justice and peace in the world", and its article 1 states the belief that human beings are free and equal in dignity. While this Declaration acknowledges the importance of dignity, the fact that the Declaration is accepted by countries across the world with diverse cultures, religions and beliefs demonstrates that dignity is held to be a global and fundamental principle.

Human dignity plays a particularly essential role in bioethical international instruments. UNESCO is the vanguard in this regard. In its Bioethics Programme, UNESCO aimed to set ethical standards in bioethics. As a result of attempting to provide such standards, the Universal Declaration on the Human Genome and Human Rights in 1997 (UNESCO, 1997), and subsequently, the International Declaration on Human Genetic Data in 2003 (UNESCO, 2003), and the Universal Declaration on Bioethics and Human Rights in 2005 (UNESCO, 2005) were adopted. In all these documents, the concept of dignity has a basic status[59]. In all these documents the concept of dignity has a foundational role. Not only has dignity been mentioned in international documents, but it has also been reflected in some national legal

[59] Also see the role of human dignity in regional bioethical documents, such as Convention on Human Rights and Biomedicine (Council of Europe, 1999), the Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine on the Prohibition of Cloning Human Beings, (Council of Europe, 2001), the Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin (Council of Europe, 2006), the Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research, (Council of Europe, 2007), and Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Genetic Testing for Health Purposes (Council of Europe, 2008).

systems. For example, the Republic of South Africa in its constitution (South Africa, 1996) names dignity as the first value of the country. Article 10, in particular, explains the value of dignity in that country: "Everyone has inherent dignity and the right to have their dignity respected and protected"[60].

The concept of human dignity has the capacity to be seen as a global concern. This adds convincing support to my suggested ethical principles which are based on a concept of dignity as given by the Capabilities Approach. It might be argued that the reason for such global agreement on the concept of human dignity is because of its vagueness. While I accept that the concept of human dignity has a level of ambiguity, I tried to lessen this ambiguity by considering it within the framework of the Capabilities Approach. The meaning of dignity in this regard, as a 'decent life', although still somewhat vague gives a more concrete sense to this notion, as it is about an acceptable quality of life. This sense provides a more practical feature by connecting the notion to the list of the central entitlements of human beings. By employing the sense of dignity as found in the practical theory of the Capabilities Approach, I hope to reduce its vagueness for hospital designers. The non-metaphysical nature of Nussbaum's notion of dignity is essential in this regard.

Given that reaching an 'overall consensus' is essential for Nussbaum, she tries to give a non-metaphysical understanding of the concept of dignity, so that people with different doctrines and religions can accept it. In a similar way, since my suggested ethical principles of hospital design are based on such a non-metaphysical sense of human dignity, I hope that the ethical principles will be acceptable for people with different culture, beliefs, and backgrounds.

3.2.4. The Problem of Marginal Cases

As was explained in section 2.6.1., one of the main concerns of Nussbaum is impairments and marginal cases; people who are not fully moral and rational agents and who are, therefore, not considered dignity-bearers in the Kantian account of dignity. The Capabilities Approach considers them valuable according to its general theory of human dignity. This point is important for hospital designers who have to provide a suitable environment in mental hospitals. (The condition of losing rationality, in some interpretations, can be applicable to those who temporarily lose their autonomy. In this sense, the problem of marginal cases would

[60] Also see the the constitution of Germany in which dignity has been named in the chapter of Basic Rights (Germany: article 1, 1).

be relevant for almost all cases of hospital design.)

3.2.5. Capabilities, rather than Functioning

What is important for Nussbaum is a focus on capabilities, rather than functioning. In other words, our responsibility is to provide sufficient opportunities and facilities for the dignity-bearers so that they can practice their capabilities. However, it is for them to decide whether or not they wish to practice their capabilities. This approach has a deep compatibility with the nature of hospitals as facilities. Hospitals are basically facilities, which means they provide opportunities. As the whole idea of the Capabilities Approach is based on the assumption that we should provide for opportunities, it is exactly defined in the way that hospitals functions.

3.2.6. Institutional-Oriented Theory

Nussbaum insists on the role of institutions in advancing the ideas of the Capabilities Approach in a just society. In other words, she emphasises the responsibilities of people in the forms of institutions and legal systems. Although in this thesis I am looking for the ethical responsibilities of designers, I will offer a two-faceted method for hospital design: one part of it is related to designers, as I will address in the next chapter. However, the other part of this method of design concerns human entitlements in hospitals. I think the role of institutions regarding the entitlements of human beings in hospitals is central. This is due to the fact that in order to recognise the entitlements of people in hospitals it is necessary to consider the discussions and findings of many different disciplines (e.g. design and architecture, medicine, ethics, social science, etc.). In this regard, we need responsible institutions that can gather the information from all of these different disciplines and design a programme upon which the relevant arguments can proceed. I will explain more about the role of institutions in enhancing the ethical method of design in the present chapter[61].

3.2.7. The List of Entitlements; A Practical Approach

Nussbaum's strategy of introducing a list of basic entitlements for human beings is another vital advantage of the Capabilities Approach. As was mentioned in section 3.1.3.2., after

[61] See section 3.5.

linking the sources of human dignity to capabilities, Nussbaum advanced her arguments by rendering a list of ten basic entitlements. This list of capabilities gives a more concrete sense to both the notions of human dignity and rights, in which the central aspects of human life are specified. It is particularly important that Nussbaum clearly introduces ten capabilities and their definitions as the basic entitlements of human beings, as this provides a more understandable conception of patients' dignity and rights for designers. In other words, by having such a list of entitlements, designers will have a more transparent understanding of the concept of patients' rights as reflected in the relevant documents. This could depict more practical features of the concept of human dignity; a notion which seems abstract and difficult to link to the embodied aspects of human beings. Adopting Nussbaum's list, I will render a specified list of the environmental entitlements of people in hospitals in the present chapter[62].

3.2.8. The List of Entitlements; Open-Ended

As mentioned before, Nussbaum proposes her list of capabilities as open-ended and subject to change:

> The list of features we get if we reflect in this way is, and should be, open–ended. For we want to allow the possibility that we will learn from other societies to recognize things about ourselves that we had not seen before (Nussbaum 1993: S55).

The flexibility of the list presents an opportunity for us to bring the list into the context of hospital design. In this regard, I will suggest a list of central entitlements of people in hospitals, which will be a specified version of the Capabilities Approach tailored for the environmental purposes of hospitals. This advantage of Nussbaum's theory facilitates the identification of a suitable method of hospital design; a method which I will call the 'Dignity Approach'.

3.2.9. The List of Entitlements; Generality

As was mentioned earlier, Nussbaum has tried to design her list in a general way so that an 'overlapping consensus' is possible. The generality of the list of entitlements is essential for designers. Although designers provide hospitals which are platforms for medical services, the field of design itself is related to 'art'. As an artist, designers should be flexible in selecting the appropriate elements, technologies, methods and forms of design. If they are limited, by

[62] See section 3.5.

being forced to use some certain elements or forms of design, they will lose their sense of flexibility and creativity. It may cause them to be unable to incorporate all of the requirements (including ethical entitlements) in their hospital design[63]. The generality of Nussbaum's list of entitlements is important in this respect in that it directs designers to the main requirements of hospital users, but keeps them flexible in choosing the most appropriate elements of design to address those entitlements.

3.2.10. The List of Entitlements: No Trade-Off

Nussbaum believes that all human capabilities are worthy and need to be supported. This implies that we should not trade-off between human entitlements (Nussbaum 2006: 166). The list of human entitlements should be seen as a whole, and they should be coherently provided for. Therefore, if there is a conflict between the entitlements of human beings, this signifies that the list of entitlements and the defined threshold levels of basic entitlements are not set rightly, and hence, that they should be redesigned. Despite this suggestion, Nussbaum believes that if a situation arises in which it is not possible to support all capabilities, it would be purely a practical question what to do next; in terms of justice we can just say "justice has not been fully done here" (Nussbaum 2006: 175).

However, the fact is that in practical cases sometimes we need to decide between some entitlements. Nussbaum herself challenges this notion of a trade-off when she tries to address conflicts between the well-being of animals and the well-being of humans (Nussbaum 2006: 402). Particularly in the case of killing animals to provide human food, or in the case of using animals for research, she endeavours to give some practical solutions. For example, for the case of killing animals for meat, while she accepts that at the moment we cannot eliminate the need for meat, for the time being she suggests the good treatment of animals during their life, and a painless killing (Nussbaum 2006: 402). This indicates that Nussbaum herself has faced the challenge of conflict between entitlements, despite her general position of rejecting trade-offs. Perhaps it is unavoidable for Nussbaum to have to *decide* between entitlements in practical cases, because of her subjects of study – e.g. justice, animal rights, etc. However, in my view, designers *can* avoid making trade-offs.

It is worth noting that there is a considerable difference between the objects of Nussbaum's theory (i.e. humans and animals) and the objects of hospital designers (i.e. hospitals). Humans and animals are (generally speaking) unchangeable subjects. In contrast, designers *create* their

[63] I will talk about creativity and incorporation in the field of design in the next chapter, section 4.7.2.

own subject (i.e. hospitals). They can select between elements, materials, technologies, and forms of design in order to *incorporate* all ethical requirements, rather than deciding between them. Therefore, the cases in which designers cannot incorporate all requirements are rare[64]. Hence, designers *can* avoid making trade-offs between entitlements. Thus, the position of Nussbaum in rejecting trade-offs can be considerably inspiring for designers as it highlights the importance of the fact that every single human entitlement matters. As designers can incorporate all requirements, they must do so; this conception is the essence of the notion of 'no trade-offs'. This is another vital feature of Nussbaum's Capabilities Approach which encourages us to select her theory as the appropriate theory for considering the ethical concerns of hospital designers.

In summary, I listed the ten features of Nussbaum's Capabilities Approach which, in my view, make this theory suitable for hospital designers. In addition to noting the compatibility of this theory with hospital design, I will identify the three ethical principles of hospital design based on some of the central notions of Nussbaum's Capabilities Approach. In fact, the method of design that I will explain in this thesis is established on the basis of Nussbaum's theory. It is worth mentioning again that this is my suggestion for an ethical approach in hospital designing. Others may suggest other strategies to deal with this issue, or find ethical principles for hospital designers by using other theories. Therefore, my claim is not that Nussbaum's Capabilities Approach is the *only* theory which is suitable for this purpose. However, given the advantages of this thesis identified above, and given that I will identify the ethical principles of design by using this theory, I think it is justifiable to choose this theory to direct the arguments of this thesis.

3.3. Ethical Hospitals in NHS Documents

Thus far, I have tried to develop the main ethical arguments in the context of the hospital environment, with a focus on the notion of human dignity, and the subsequent entitlements. I endeavoured to develop these notions by investigating and providing arguments about them as found in the Capabilities Approach. We now have a list of basic entitlements, suggested by Nussbaum, which can be considered as the benchmark of a dignified life. To bring this list into the context of the hospital environment, however, we need to see what ethical requirements are essential in the context of hospital environments and then reflect those requirements in Nussbaum's list of entitlements. In this way we can have a list of basic

[64] I will expand this argument in the next chapter, section 4.7.2.

entitlements which is specified for the hospital environment. Such a list of entitlements is one part of my dual-faceted design approach which will be completed with the three ethical principles in the next chapter.

As mentioned above, many disciplines and fields of study can offer suggestions to improve a specified list of the environmental entitlements of people in hospitals. However, since in this research I am focussing on the theoretical aspects of the ethical method of hospital design, I will only suggest an initial list of entitlements by considering two kinds of resources. This means that this initial list should be considered a starting idea that can be enhanced by incorporating the considerations and findings of other disciplines or documents. The first resource for modifying Nussbaum's list is the relevant documents of the healthcare services. This is because we can usually find some reflections of the practical experience of medical professionals in such documents. For this purpose, I will investigate the Health Building Notes (HBNs) published by the NHS (the UK's National Healthcare System).

As will be explored, the NHS gives considerable reflection to the non-medical requirements of people in hospitals, which makes it a suitable study case. It is worth emphasising that my study on HBNs is only a *sample* study, through which I hope to find some ideas concerning the practical findings in hospitals. I admit that some other references might be suggested with further ideas for modifying the specified list of entitlements, and these should be welcomed. As my aim is to give some general directions about the ways in which the list of entitlements can be specified for the context of the hospital environment, I think concentrating on the NHS's document is sufficient for this aim. This is because the NHS provides good reference to the non-medical requirements of people in the HBNs.

The next source of study in specifying the list of entitlements is the empirical findings reflected in scientific articles. Studies have shown that the environments of hospitals can affect the condition of people in hospitals. Therefore, we can consider the findings of those studies in the list of entitlements. For this purpose, I will consider a literature review in which those findings are explored. And finally, after considering the NHS documents and these scientific findings, I will offer an initial list of the environmental entitlements of people in hospitals. As mentioned earlier, this list can be improved upon by considering the findings and arguments of other disciplines, as well as by taking into account the concerns of other healthcare systems.

3.3.1. Dignity in the NHS Documents

In this section I am going to explore the documents of the healthcare system of the UK as a

sample investigation in order to see how the ethical requirements of people are reflected in such documents. In this case study, I will consider how the notion of dignity in these documents is linked to the suitable environment of hospitals. And then I will focus on the specific documents of the NHS (i.e. HBNs) in which there are some signals of the non-medical expectations of hospital environments. The National Health Service (NHS) in the UK started in 1948 after the Second World War due to the subsequent feeling of the need for a reconstruction of the country. Recognition of healthcare as a human right, rather than something which should be provided in the form of a charity system, was one of the leading reasons for the establishment of the NHS in the UK[65]. The NHS was based on three central principles: universality (i.e. to provide a service with at least the minimum standards all over the nation), comprehensiveness (i.e. to support for all health services required), and free delivery based on the need of people rather than their ability to pay (Talbot–Smith, Pollock et al. 2006: 2).

It is also worth noting that the NHS is one of the best healthcare systems in the world. Davis and his colleagues in their report in 2014 assessed the performance of 11 wealthy countries including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. In this survey, the UK's healthcare system was ranked top among these 11 nations. The criteria used in this ranking were quality of care (including effective care, safe care, coordinated care, patient–centred care), access (including cost–related problems and timeliness of care), efficiency, equity, healthy lives (Davis, Stremikis et al. 2014).

The NHS is also famous for its financial system. The NHS has a responsibility to provide free public healthcare service for the UK's citizens. Apart from some healthcare services such as pharmaceuticals, and dental and ophthalmic treatment, for which many people pay directly to the health providers, funding for the NHS is mostly provided for through general taxation (Marshall, Charlesworth et al. 2014: 12, NHS England 2014). As the basis of the Capabilities Approach is the notion of human dignity, it is worth exploring the general status of human dignity from the NHS perspective. The NHS Constitution for England is a suitable instance in which the principles and values of the NHS in England is established. It also defines the rights and responsibilities of patients, public and staff as well as the pledges which the NHS is committed to achieve (Department of Health 2015: 3 – 4)[66]. The NHS Constitution was first

[65] For more information about the history of NHS and hospitals in the UK see *Rivett (1986), Webster (2002), Ranade (1997: 1 – 23).*

[66] The NHS has published a handbook of the Constitution in order to provide all of the information that people need about the NHS Constitution for England (Department of Health 2015: 2). Since this

published in 2009. Afterwards, it was revised four times with the last one released in 2015 (Department of Health 2015: 10 – 12). According to this Constitution, 'respect and dignity' is one of the focal values of the NHS:

> Every individual who comes into contact with the NHS and organisations providing health services should always be treated with respect and dignity, regardless of whether they are a patient, carer or member of staff. This value seeks to ensure that organisations value and respect different needs, aspirations and priorities and take them into account when designing and delivering services. The NHS aims to foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers (Department of Health 2015: 13).

The first point in this statement of values is that everybody who makes contact with the NHS should be treated with respect. The physical environment of hospitals is undoubtedly a crucial ground for such respectful connection. Therefore, the hospital environment should be considered as a contributor of this value. It also emphasises that the respect should take place during "designing and delivering services." Providing the physical environment of hospitals should be seen as an essential part of both designing and delivering the services of the NHS. Therefore, if the dignity of people should be respected even in the designing part of the service of the NHS, then ethical issues in hospital design and construction should be taken into account as a reflection of this value of the NHS with regards to the healthcare environment. The NHS also has another central value, 'Compassion', which is described as follows:

> Compassionate care ties closely with respect and dignity in that individual patients, carers and relatives must be treated with sensitivity and kindness. The business of the NHS extends beyond providing clinical care and includes alleviating pain, distress and making people feel valued and that their concerns are important (Department of Health 2015).

According to this value, merely healing people is not the only concern of the NHS; it also worries about the quality of care and the conditions of the people who use its services. This value is applicable to the physical environment of hospitals. This is because friendly personal behaviour is not the only way people can feel the sense of kindness and care; the hospital environment has an essential role in conveying this sense to people as well. People should feel

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handbook explains the Constitution in more detail, in this part I am going to refer to the handbook, rather than the main Constitution.

that the design of the hospital is delightful, and that its designers were sensitive about their concerns and entitlements. Moreover, the second sentence points to a crucial issue in stating that the NHS should not only provide for clinical care, but should also strive to reduce people's pain and distress. As will be mentioned below[67], a vast body of research emphasises that the design of a hospital can reduce the pain and suffering of the patients.

Thus, hospital design should be considered a tool with which the NHS can meet the standards of this value. Merely considering these two values of the NHS – namely 'dignity and respect' and 'compassion' – is sufficient to conclude that human dignity is one of the central concerns of the NHS. However, the meaning of dignity in this document does not seem to be adequately clear or instructive for designers. The NHS Constitution for England, on page 53, has established a right of being treated with dignity and respect, in which it endeavours to define dignity and respect:

> The right to dignity includes a right not to be subjected to inhuman or degrading treatment. The right to respect includes the right to respect for private and family life.
>
> This right has broad meaning, but for the NHS your care, where possible, should be provided in a way that enables you to be treated with dignity and respect (Department of Health 2015: 53).

The apparent sense of dignity defined in this quotation is less relevant to the hospital environment. It seems instead to be about the ways in which medical staff should behave towards their patients. The concept of respect, however, seems to require more in relation to environmental issues, i.e. to provide private areas for patients as well as suitable spaces for being with their families. However, these definitions are not compatible with the aforementioned philosophical accounts of dignity and respect (both accounts of dignity provided by Kant and Nussbaum). As I explained earlier, Nussbaum depicts a wide range of implications for the concept of dignity and respect (i.e. the list of basic entitlements). Moreover, the meaning of dignity as a decent life, and respect as providing for the entitlements of people in hospitals, has much more directive sense than what the NHS suggests. Therefore, it seems a Nussbaumian perspective on the notions of dignity and respect is more illustrative for designers when identifying their ethical responsibilities than what they may understand from such documents.

The constitution, however, determines a right which is more directly related to the environmental aspects of hospitals, which is the right "to be cared for in a clean, safe, secure

[67] See section 3.4.

and suitable environment" (Department of Health 2015: 40). This right is considered not only for patients, but also staff, visitors and other NHS service users:

> The quality, design and general upkeep of healthcare premises has a material impact on the health and wellbeing of those using them. Those providing your care and treatment must take reasonable steps to ensure it is delivered in appropriate premises with adequate equipment (Department of Health 2015: 40).

Therefore, the "appropriate" environment is a concern for the NHS. However, it seems these environmental concerns of the NHS are reflected in an unclear and scattered manner in the constitution; they are not detailed in a way that a designer can transparently discover the relevant elements and forms of design. Nevertheless, this does underscore the importance of people's dignity and rights for this healthcare provider. To have more specific regulations for the condition of a healthcare building, however, the NHS has provided a set of guidelines on the design and planning of hospitals. By considering these guidelines we can find some points concerning the practical experiences of people and staff in hospitals which can be addressed and facilitated by environmental means.

3.3.2. The Health Building Notes (HBNs)

The Health Building Notes (HBNs) as "key documents" and "national best–practice guidance" are provided by the Department of Health to direct the design and planning of new healthcare buildings as well as developments of existing facilities. HBNs are provided on 17 major topics, all of them organised under the considerations of the main issues in design and buildings addressed in the Health Building Note 00–01 (Department of Health 2014). As the ethical requirements of people are mainly reflected in this document, I will concentrate on HBN 00–01 to discuss the practical concerns of hospital environments.

In the Policy and Regulatory part of this HBN, one of the main aims of HBNs is to "promote the design of healthcare facilities with regard to the safety, privacy and dignity of patients, staff and visitors" (Department of Health 2014: 6). However, it is important to see how the concept of dignity is considered in this document and how it guides regulations. In part three of this HBN, 'Building Design', there is the 'Privacy and Dignity' subsection which addresses some patients' concerns in hospitals. A few issues are noted in this subsection, such as the importance of same–sex accommodation in hospitals, taking account of patients' cultures and preferences and the like. Giving such practical instances, the HBN shows that it is able to deal with some ethical dilemmas related to the hospital environment.

The value of people who use hospitals is also considered in other subsections, even though it is not classified in terms of human dignity. The next subsection, entitled "Inclusivity", emphasises that "design should be responsive, taking account of what people need and want […]" (Department of Health 2014: 23). In other pages, it claims that concentrating on the needs and activities of patients, staff and others in hospital design would be more beneficial than beginning with the function of rooms (Department of Health 2014: 27). Accordingly, the HBN expects the voice of the patients and the public to be heard from the very beginning of the process of planning (Department of Health 2014: 9).

As well as giving due note to the importance of responding to users' opinions when engaged in hospital design, this HBN also attempts to address some particular functions of the hospital environment that should be recognised by designers as well as hospital commissioners. For example, it depicts "reconciling the need for patient safety, effectiveness and efficiency and the need for creating a truly therapeutic environment" as the main problem which commissioners, regulators and providers of healthcare buildings have to deal with (Department of Health 2014: v). Therapeutic design, which is highlighted in the HBN, can actively contribute to the healing of patients in hospitals - which I believe is part of the ethical duties of designers towards patients:

> Healthcare facilities should provide a therapeutic environment in which the overall design of the building contributes to the process of healing and reduces the risk of healthcare–associated infections rather than simply being a place where treatment takes place (Department of Health 2014: vi).

Accordingly, the Department of Health recommends the Evidence–Based Design approach as a method of healing design as well as a suitable way to save time and costs[68] (Department of Health 2014: 6).

Based on these expectations of the conditions of a hospital environment, many instances are explained by the HBN to ensure that the needs of people in hospital are addressed sufficiently. For example, the necessity of providing a private environment for patients and their family, the ability of people to have control over their environments, flexible design for persons with different perspectives, religions, race, gender, etc., providing suitable spaces for families to remain in hospital with their hospitalised family members, nature and art in hospitals, the

[68] I will explain the Evidence-Based Design (EBD) approach in hospitals in the next chapter, section 6.8. In short, in this approach, a hospital designer considers the literature in which the effect of the environmental elements of the hospital on people are investigated, and attempts to reflect those findings in her design.

condition of the toilets, and many other items are mentioned in order to illustrate the expectations of the NHS for their hospitals. These expectations are explained in detail so that designers clearly understand the main concerns of the NHS in each of these issues. For example, in terms of the condition of the toilets in hospitals, the HBN reflects patients' expectations:

> Patients prefer toilets to be near and to be clear about their location with the actual door not in full view of many other people. They also would like toilets and bathrooms to have a degree of sound privacy and not to cause smells. Patients would like to be able to freshen up, be clean, shave and be presentable (Department of Health 2014: 34).

To conclude, the NHS is evidently concerned with the dignity of people. Accordingly, many parts of the HBN reflect the NHS's expectations concerning people's dignity and entitlements in hospital. Moreover, to avoid missing important ethical elements in hospital design, the NHS tries to specify its expectations by giving detailed explanations of each part. For example, looking at the part on Dignity and Privacy, the importance of accommodating patients in same–sex places as well as the necessity of considering the preservation of the privacy of patients, particularly at the point of transfer between different parts of the hospital, is emphasised. By explaining what people want from the physical environment, a hospital designer can focus on the issues which are important for their client (i.e. the NHS). This is one of the benefits of such healthcare systems documents in that, to some extent, the dignity of people in the hospital environment can be respected.

Not all healthcare systems have such documents with concerns about non-medical requirements in hospitals. However, the same approach can be seen in some other guidelines such as *The Guidelines for Design and Construction of Hospital and Healthcare Facilities* published by The American Institute of Architects Academy of Architecture for Health (AIA 2001). Although this guideline mainly deals with the technical aspects of hospital design, there are some references to human dignity and entitlements related to the hospital environment (e.g. stress, privacy, confidentiality, etc.).

Nonetheless, I believe that hospital designers have to take a more substantial, separate dignity-focussed approach in their hospital design, regardless of the way in which the concept of dignity is reflected in such regulations. As was explained earlier, the HBNs determine the elements of the design of an ethical hospital in detail (such as the condition of the toilets mentioned before). This can help designers to understand their clients' needs more clearly. However, this strategy can have negative results at the same time. This is because it can

marginalise other potential ethical conditions which can appear in each individual case of design.

Respect for human dignity and entitlements in hospital design can be realised in numerous shapes and forms. A designer who commits to providing for the entitlements of people in hospitals may find several levels and elements of design suitable for this purpose. However, if a designer sees his ethical obligations only in terms of the NHS expectations addressed in the HBNs, this may cause him to ignore his other potential ethical responsibilities. This is because each hospital has its own individual and unique characteristics, which demand specific considerations of the relevant ethical conditions that may happen in that particular hospital.

While I admit that recommendations such as the HBNs' are principal in advising designers as to the main expectations of the hospital environment, this does not remove the importance of an ethical method of design by which designers can find their ethical responsibilities systematically. Recommendations such as the HBNs, then, can (or in fact should) be part of an ethical method of hospital designers. All in all, designers have a moral responsibility to respect the dignity of people in hospitals whether their clients ask for it or not. A more comprehensive dignity–based approach for designers would encourage them to think beyond the standards of the NHS, and provide for any elements which can enhance the ethical condition of people in hospitals, even if it is not required in those documents.

My suggestion, therefore, is not that the NHS should withdraw from providing such requirements and standards for hospitals. Rather, my proposal is that the NHS should determine such demands within the systematic framework of an ethical approach to hospital design. In this way, not only can the NHS ensure that it is reflecting concerns about the hospital environment, but a moral designer who takes an ethical approach in his career can also conform to those expectations relating to the method of design. For this purpose, I will suggest a list of the basic entitlements of people in hospitals. Such a list, which is inspired by Nussbaum's list, can on one hand be a basis for the NHS to recognise the important expectations of people. On the other hand, a hospital designer who takes my suggested dignity approach, can adopt that list and its recommendations for his ethical principles. Despite the above arguments about the NHS recommendations concerning the environment of hospitals, such recommendations can be considered when specifying and enhancing Nussbaum's list of entitlements for the context of the hospital environment. However, there is another resource for specifying the list of entitlements, namely scientific findings.

3.4. Scientific Findings

There is ample research and evidence which indicates the positive (or negative) impact of the hospital environment on people. This evidence motivates hospital designers to take an approach in which the findings of such research are considered in the process of design. I will analyse this approach in the next chapter[69]. I think such research can be considered another resource for specifying the list of entitlements in the context of the hospital environment. In this section, I will mention a few such findings as examples and in the next section I will offer my initial list of entitlements in hospitals, as according to Nussbaum's list when specified by considering practical experience (as mentioned in the HBNs), and the findings of studies.

In 2004 a research team from Texas A&M University and the Georgia Institute of Technology reported a literature review of several thousand scientific articles which was about the effect of the hospital environment on clinical outcomes. They identified over 600 of those studies as the most rigorous studies. In that report, entitled '*The Role of the Physical Environment in the Hospital of the 21st Century: A Once–in–a–Lifetime Opportunity',* they categorised the results of those studies (Ulrich, Zimring et al. 2004). Based on that research, four years later in 2008 the literature review was updated and expanded into another report entitled *'A Review of the Research Literature on Evidence–Based Healthcare Design.'* The questions which were explored in this report were: "(1) [What] can rigorous research tell us about "good" and "bad" hospital design? (2) [Can] improved design make hospitals less risky and stressful and promote more healing for patients, their families, and staff? (3) [Is] there scientifically credible evidence that design affects clinical outcomes and staff effectiveness in delivering care?" (Ulrich, Zimring et al. 2008)

However, these three questions explored in the report by Ulrich and his colleagues are not all a hospital designer can consider. The central entitlements of human beings regarding their capabilities involve far wider issues than merely concerns about stress, risk, clinical outcomes, effectiveness and the like. Nonetheless, this report can represent a substantial part of the efforts a designer should make to support human capabilities. Therefore, the findings of such research can be utilised for specifying Nussbaum's general list in the context of hospital design.

This literature review explains what elements of hospital design can have an effect on the condition of people in hospital. My investigation of this literature review reveals that those elements can remove or mitigate eighteen kinds of harm[70], such as infection, falling on the

[69] See section 4.8.

[70] By saying harm, in this section, I mean to be deprived of reaching the thresholds of entitlements.

floor, stress, and the like. I am going to list some of the harms which the elements of design can affect, as sample explanations of the ways in which people might be deprived of their basic entitlements by the environmental means of hospitals. In this regard, I will look at some evidence which explains how those harms can impact human beings. I will then explain how such impact can be considered harmful according to the definition of the basic capabilities given by Nussbaum. This suggests how such harms can be inserted into the list of human entitlements in hospitals[71]:

- *Reducing Hospital–Acquired Infection*: Serious infection can be considered to be losing one's healthy condition, which means there has been a reduction in the bodily health capability. Therefore, when the infection is serious enough, being infected can be seen as being below the thresholds of this capability. Since serious infection can undermine the bodily health capability, when designers do nothing to prevent or mitigate the risk of this vulnerability, they fail in their duty to respect the dignity of patients. As will be mentioned later[72], this is due to the fact that studies have shown that the design of a hospital can considerably reduce this risk.

- *Medical Errors*: the report recognises the cause of medical errors in hospitals as a combination of active failure and latent conditions: "Active failures are caused by the unsafe performance of caregivers or by the system through lapses, mistakes, and procedural violations. Latent conditions are established by designers, builders, and top level management and they make errors more likely" (Ulrich, Zimring et al. 2008: 78). The hospital environment can indirectly affect the number of medical errors[73]. Medical errors can threaten certain capabilities such as bodily health, or even the capability of life. This threat should be lessened by designing a hospital in the appropriate way. Therefore, the risk of medical errors is one of the harms which can threaten the capability of bodily health.

- *Reduction in Patient Falls:* Falling on the floor is one of the most frequently reported

[71] To avoid prolonging the discussion of this section, I am not going to consider *all* of the possible effects of these harms (e.g. infection, medical errors, etc.); only *some* of those effects will be discussed to show that there is some evidence of them. Thus, the following explanations are not about *all* negative effects on human capabilities, and one may be able to count more diverse impacts for each of those harms.

[72] See section 4.4.2.

[73] See section 4.4.2.

accidents in hospital. For example, in a period of 12 months over 200,000 falls were reported from inpatient settings in 472 NHS organisations, and in 26 cases it resulted in the death of patients (National Patient Safety Agency, 2007: 11). Whether the result of falling is fracture, cuts, bruises, or even death, it threatens to bring people below the capability thresholds of life or bodily health in hospitals. Therefore, as with the issues of serious infection and medical error, falling is an instance of the potential harm that a patient faces in hospital.

The same report by the National Patient Safety Agency provides a list of elements of design which can impact on this harm, such as flooring surface (including any unevenness, and how slippery it is when wet or dry), flooring density (including how soft or hard a surface is to land on), flooring pattern (as it can create the illusion of slopes or steps to impaired eyesight), lighting (including poor lighting, sudden changes from dim to bright lighting, and the position of light switches), the design of doors (and hand rails, toilets, and bathrooms), and so on and so forth. Even additional curtains or screens in toilets allow nurses to be near to the vulnerable patients so that they can protect patients without offending their privacy (National Patient Safety Agency, 2007: 45). Therefore, designers can play a significant role in protecting patients from falling on the floor; and this suggest that a safe hospital with a low risk of potential harms can be considered in the list of peoples' entitlements.

- *Reduction of Pain*: Some of the findings of scholars have already been mentioned in Nussbaum's list of capabilities. For example, "being able to avoid non–beneficial pain" is one part of Nussbaum's description of the capability of Senses, Imagination, and Thought. As I will mention[74], some design elements can mitigate such harm considerably. Therefore, some items of Nussbaum's proposed capabilities are already suitable for the hospital environment, and just need to be emphasised or altered.

- *Reduction in Stress*: Studies suggest various ways of reducing the level of stress experienced by people in hospitals. However, stress causes suffering to people in hospitals through various kinds of harm. For example, an increase in the risk of infection and clinical colds is one of the results of psychological stress for patients in hospital (Cohen, Tyrrell et al. 1991). In another study, for instance, it was shown that patients who experienced more stress in hospitals report more pain and lower physical status than those with less stress (Volicer 1978). The healing of wounds, another example of (overcoming) harm, can be delayed by

[74] See section 4.5.2.

stress (Kiecolt–Glaser, Marucha et al. 1995). Some sources of stress, such as noise, are part of the hospital environment. Consequently, attempts to reduce the environmental sources which cause (or increase) stress for people in hospitals can be counted as one of the designers' obligations. Thus, the reduction of stress can be reflected in the list of human entitlements in hospitals.

- *Reducing Depression*: Depression is a fundamental and common problem in hospitals (Ulrich, Zimring et al. 2008: 90). Depression has different symptoms, any of which can be considered as involving a loss in capabilities. For example, a lack of interest and a lack of pleasure are symptoms of depression (Sherdell, Waugh et al. 2012, Blanco, Barnett 2014). This can be seen as a lack of the capability of play as defined by Nussbaum: "Being able to laugh, to play, to enjoy recreational activities" (Nussbaum 2008: 77). Depression can also involve physical symptoms such as "feeling constantly tired, sleeping badly, having no appetite or sex drive, and complaining of various aches and pains" (NHS 2015).

These symptoms can be considered to be threatening a number of capabilities such as the bodily health capability, the bodily integrity capability, and the senses, imagination, and thought capability. In the severest of cases, depression can lead to suicidal feelings, and so threaten the capability of life. Therefore, in many respects, depression can be considered a condition that can bring people's capabilities below the threshold levels and, therefore, hospital designers have an ethical duty to design the hospital environment in such a way so as to facilitate supporting depressed people. Depression, as we have seen, can be considered important with respect to a number of capabilities but the capability of play seems to be the most relevant.

- *Reducing Length of Stay*: In accord with Nussbaum, we can also say that staying in hospital can involve a lack of the capability of bodily integrity (being able to move from place to place) as well as the capability of play and others. Therefore, aiming to reduce the length of time people have to stay in hospital is a duty of all involved. For example, as will be mentioned[75], bright rooms in hospitals can help to lessen the length of hospital stays. The restriction imposed by being within the hospital environment is an inevitable harm which should be reduced as much as possible. It is, therefore, implicitly relevant to some capabilities,

[75] See section 4.8.1.4.

particularly the capabilities of play and bodily integrity.

- *Reducing Spatial Disorientation*: A well–designed hospital has a clear wayfinding system in which people can reach their destinations easily. Wayfinding problems are described as "costly and stressful and have a particular impact on outpatients and visitors, who are often unfamiliar with the hospital and are otherwise stressed and disoriented" (Ulrich, Zimring et al. 2008: 92). The particular impacts of unsuitable wayfinding systems were not clarified by the authors of the report. Nevertheless, when we claim that the hospital environment should not cause stress for people, this can involve considering disorientation and inappropriate wayfinding systems.

As was mentioned, there are thousands of examples of research that studies the effect of different elements and characteristics of the hospital environment on people. The eight effects mentioned above are samples to show the importance of the quality of the hospital environment. In the next chapter, I will discuss such research in more detail, and I will explain how such evidence might lead designers to consider these issues in their design process. However, my main reason to recount some of these effects is to underscore the fact that the findings of such literature can be used for specifying the list of human entitlements in hospitals.

Many of the points studied in the literature can be considered entitlements of people in hospitals. Nevertheless, the problem is that these studies are scattered and have been arbitrarily chosen by the researchers. Having the list of basic entitlements can assist in organising these entitlements under some general headings (i.e. the titles of the capabilities listed by Nussbaum). Therefore, such a list has a dual benefit for researchers and designers. On the researcher side, the list of entitlements can guide them to recognise the less-studied entitlements of people and can therefore encourage them to work more on those areas, the result of which would be to have a better literature related to the hospital environment. On the designer side, the list of entitlements can assist them to easily identify the main considerations that they have to provide for. This means that instead of needing to investigate the available research in order to find the suitable work for their individual project, they can have a general list of entitlements that is already specified with an updated list of people's entitlements in hospitals.

3.5. The Specified List of Entitlements

Up until now, I have tried to provide some ethical arguments to act as a basis for people's entitlements in hospitals, by addressing the status of human dignity and its implications according to Nussbaum's Capabilities Approach. One of the results of such moral arguments is the list of human entitlements that Nussbaum suggested as a minimal interpretation of a 'decent life'; a life which is compatible with human dignity. We also talked about the practical experience of the NHS as a sample of regulations in the context of hospital design. We then addressed some of the empirical findings discussed in various articles, highlighting the relation between the environment and people's well-being in hospitals. All things considered, I suggest the following specified list of entitlements for people in hospitals[76]:

1.*Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.

2.*Bodily Health*. Being able to have good health, ***[and to have adequate access to an appropriate healthcare service (including a respectful medical environment) sufficiently facilitated to accept and to treat patients in order that they are cured as soon as possible with minimum risk of potential harms such as medical errors, infections, falling on the floor, etc.] […];*** to be adequately nourished; ***[…; to be suitably supported when one is in a vulnerable situation such as being sick.].***

3.*Bodily Integrity*. Being able to move freely from place to place ***[attempts to support this capability can involve endeavours to lessen the length of stay in places which can involuntarily deter practicing this capability such as being in hospitals]***; ***[…] [to be secure against violation of the right to privacy including unwanted public–viewing, disclosure of personal information (including medical information) without consent, being overheard by others; to be able to have a confidential discussion with medical professionals; having the opportunity to take shelter in a private and segregated area].***

4. *Senses, Imagination, and Thought*. Being able to use the senses, to imagine, think, and reason–and to do these things in a ''truly human'' way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical

[76] What I added to Nussbaum's definitions is shown with square brackets '[]' in a ***bold italic*** font, and what I erased is shown with ***[…]***. To find Nussbaum's unchanged definitions of capabilities see section 3.1.3.2.

and scientific training. Being able to use imagination and thought in connection with experiencing and producing works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise ***[including having access to an appropriate place in which to practice religious, cultural, or personal ceremonies and conduct]***. Being able to have pleasurable experiences and to avoid non–beneficial pain.

5. *Emotions*. Being able to have attachments to things and people outside ourselves ***[including within environments designed to support this capability in particularly vulnerable situations such as being in a hospital]***; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by fear and anxiety. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development ***[including having access to an environment in which one can get support from family and friends]***).

6. *Practical Reason.* Being able to form a conception of the good and to engage in critical reflection about the planning of one's life. (This entails protection for the liberty of conscience and religious observance[77].)

7. *Affiliation*.

A. Being able to live with and toward others ***[including having access to a suitable environment to see people to whom one has an attachment (e.g. family and friends[78])]***, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation ***[…]***)

B. Having the social bases of self–respect and non–humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails provisions of non–discrimination on the basis of race, sex, sexual orientation, ethnicity, caste, religion, national

[77] The instances of capabilities are not absolutely distinct and they may overlap in some cases. In this item, the religious considerations of this capabilities, to some extent, address the same issues as those involved in the fourth capability.

[78] This item more or less overlaps with the capability of emotions, too. However, what is the core in the capability of emotion is getting support from families and friends, while the main issue in this affiliation capability is being with relatives.

origin.

8. *Other Species.* Being able to live with concern for and in relation to animals, plants, and the world of nature ***[including having environmental opportunities relevant to this capability[79]]***.

9. *Play.* Being able to laugh, to play, to enjoy recreational activities ***[including access to an environment which facilitates this capability. Such an environment should be able to help relieving and not causing stress, anxiety, and depression].***

10. *Control over One's Environment.*

[…] [being able to prevent others from entering into the surrounding environment without consent when it is not necessary (e.g. emergency cases); having reasonable control over the condition of the surrounding environment such as its heat, brightness, air condition, etc.; being able to be in or to have access to a private area[80]; being able to use a public environment (such as that in hospitals) with a clear plan and signs that assist in finding desired destinations; being able to work in an environment designed and laid out to minimise negative impacts such as fatigue, and avoidable injury and stress].

This is my suggested list of people's entitlements in hospitals. I provide this list as an important part of the ethical method of design– namely the dignity approach – which I will explain in the next chapter. In this method, we first need to determine the main ethical requirements of people in terms of the hospital environment. Having such a list of entitlements, we can then offer some ethical principles as directions for the ways in which hospital designers can provide for those entitlements. Therefore, in order to direct designers in their job, we first need to determine what is expected from the hospital environment.

This list of entitlements has ethical arguments as its basis (i.e. the arguments concerning the concepts of dignity and entitlements in the Capabilities Approach in the current and previous chapters), which was then enhanced by considering some references to practical experiences

[79] Some research shows animal–assisted therapy in hospital can have positive impacts on patients. For example, Püllen et al. (2013) believe that "animal assisted therapy improves mood, communication and activity in patients with cognitive impairment"; and that since they observed no negative effects, such "therapy can be safely established in a hospital".

[80] The main concern for privacy in this capability is about the ability of people, particularly patients, to have control over their surrounding environment, while the key issue in the capability of bodily integrity, in terms of privacy, refers to protecting people from violations against their privacy.

(e.g. the NHS documents), alongside some empirical findings in the literature. However, as with Nussbaum, I consider the above list of entitlements open-ended and subject to change. The issues, references, and arguments I addressed in this thesis constitute a small picture of what needs to be done in this new field (i.e. the field of ethical considerations in hospital design).

I only strived to depict the general idea and provide the main direction for this field by referring to some sample evidence and arguments. However, there are many other issues and disciplines which can contribute to developing this ethical method of design. Consider, for instance, the literature review of Ulrich et al. which I referred to. Two academic teams worked on various studies so that they could produce such a literature review. To improve the ethical method of design – which I will discuss in the next chapter – not only should we consider empirical findings, but we should also consider the thoughts and arguments in other disciplines, such as ethical arguments, discussions in social science and psychology, medicine and bioethics, and so on and so forth. Therefore, my aim in this thesis is only to underline the core features of this field (i.e. ethical approach in hospital design); this thesis is not the final word in this context - it is just the beginning. However, the list of entitlements that I have suggested can function as a foundation for future studies and debates in this field.

Overall, to develop and modify the suggested list of entitlements of people in hospitals there is a need to study and consider a vast amount of issues from different disciplines. This signifies the importance of Nussbaum's idea concerning the role of institutions in her Capabilities Approach[81]. Since any improvement of the list of entitlements needs interdisciplinary cooperation, it is necessary to determine which organisations can lead and manage such a collective attempt, in addition to preparing the subsidiary regulations and standards. This is because it is impractical to expect a designer to lead such a task on his own for every individual project.

In my view, there are three areas in which these institutions need to attempt to construct a robust account of people's entitlements in terms of the hospital environment. First, there is a need to keep the list of entitlements up to date, by constantly monitoring the latest findings of the relevant disciplines and modifying the list accordingly. In this regard, it seems that ethical arguments have an overriding role to play in shaping the essence of the list. As the list of entitlements is the basis for standards and regulations, modifying and enhancing the list of entitlements can have a vital effect on the regulations and standards of hospital design.

[81] See section 3.1.4.2.

As Nussbaum points out, the list of capabilities should be applied as a whole, and no entitlement should be sacrificed for the sake of other entitlements. Therefore, the next responsibility of authorities is to determine the thresholds of each capability. In other words, a designer or a hospital provider should be informed to what extent she has to invest in and attempt for each entitlement. For example, to reduce the risk of medical errors, many elements might be involved in the design of hospitals. But what is the reasonable level of risk of such harm? Obviously, it would not be reasonable to spend a huge amount of money to decrease just a small percent of the risk. Therefore, it is necessary that authorities judge the reasonable level of risk that should be provided for. Such levels of thresholds can tell designers to what extent they have to consider protective elements in their design (to reduce the risk of medical errors, for instance).

The growing body of research related to the effect of the hospital environment on people signifies the third responsibility of the relevant organisation: to provide appropriate guidelines for the designer. There are many guidelines for hospital designers in different countries, such as the HBNs published by the NHS, or the *Guidelines for Design and Construction of Hospital and Healthcare Facilities* published by the AIA, which, despite their scattered signals about the ethical requirements of people in hospitals, are mainly about technical issues and limitations in hospitals. Having the list of entitlements, the relevant institutions can now begin to insert the ethical requirements of people into their guidelines in more detail and in the systematic way suggested in this thesis. For example, they can dedicate a section on the standards of each kind of hospital in their guidelines. In such a section, the ways each capability can be harmed in that specific kind of hospital can be identified. For example, there is a need to clarify the ways in which the capability of play in children's hospitals can be diminished, and how this capability can make sense in a hospice setting. The empirical findings, practical experience, and even patients' ideas and complaints can guide institutions to include more appropriate items in such guidelines.

An institution can also have a list of recommendations for the ways in which human capabilities can be practiced, developed, or secured in that sort of hospital. For this purpose, again, empirical findings can assist in giving a better insight to hospital designers (e.g. using positive distraction to lessen the stress of patients in hospitals). All in all, institutions can have a leading role in providing and enhancing the list of entitlements, as well as providing regulations, recommendations, and standards, so that hospital designers can identify the needs for which they are required to design. These all can, now, be formed by the main ideas of human dignity and entitlements in Nussbaum's Capabilities Approach. Having discussed the list of entitlements of people in hospitals, it is now time to focus on the designers in order to

identify which principles they can use to address such entitlements. I will discuss the ethical principles for hospital design in the next chapter.

Chapter 4

4. The Ethical Principles

4.1. Life Worthy of Dignity in Hospitals

In chapter two, I explained that in the discourse concerning hospital environments, ethical concerns are usually stated in terms of patients' rights and dignity. I argued, however, that hospital designers might not be clear on how they ought to meet their ethical responsibilities (i.e. respecting the dignity of patients and providing for their entitlements through the hospital environment). We need to establish an ethical framework and guidelines by which hospital designers can identify the ethical responsibilities relevant to their jobs. For this sake, designers need clarification in terms of the senses and implications of the concepts of dignity and rights in the context of the hospital environment. They also need to know how the hospital environment can support people's entitlements in hospitals. For this purpose, I suggested that we ground these requirements in the Capabilities Approach which, as was argued in the previous chapter, is the most appropriate theory for the goal of this thesis. The theory defines and connects the concepts of human dignity and human entitlements in a way that can assist us in identifying the ethical principles of hospital design.

When analysing the concept of human dignity in the Capabilities Approach, I elaborated on the idea that this notion emphasises the inherent valuable status of human beings. The Capabilities Approach also suggests that this concept indicates a sense of a 'decent' condition for human life. In this light, and in order to respect the dignity of people in hospitals, not only should designers plan for the treatment process, but they should also provide for and protect people's entitlements to secure decent conditions in hospitals. What are those basic entitlements? In chapter three, I brought the Capabilities Approach into the context of the hospital environment in order to render a list specifying the basic environmental entitlements of people in hospitals. Thus far, I have presented an understanding of the concept of human dignity and its implications, and a list of the basic environmental entitlements of people in hospitals. We now need to narrow down the discussion to the issues related to designers in order to discover how hospital designers can design for such entitlements.

As was mentioned before, the central idea of the Capabilities Approach is human flourishing; the ways people can practice their capabilities. To flourish with respect to some (if not all) of our capabilities we take advantage from goods and services. For example, a car can help us to move from one place to another. However, there are many factors that can affect the

functioning of a person's capabilities when using a facility. For example, if one has a car then one can move faster than an individual who possesses only a bicycle[82]. In a similar way, someone being treated in an ethically designed hospital has more chance to practice, develop, or secure her capabilities than someone who is being treated in a hospital whose design is appropriate only for the medical process. Accordingly, we need to consider how various elements of the hospital environment, as a facility, can enable people to reach, at the very least, their minimum entitlements.

In this regard, I will suggest three ethical principles for hospital design: design for vulnerability, design for healing, and design for reverence. These principles are defined on the basis of the Capabilities Approach. I will also try to give some examples of the ways in which these ethical principles can function. Furthermore, I will explain how these principles can be utilised in the context of hospitals, and I will consider whether or not apparent conflicts between the principles can be resolved by the designers. Finally, I will explain how these principles can enhance the current methods of hospital design. However, before presenting these arguments it is worth briefly reviewing the history of hospitals in order to understand why the ethical requirements of patients have not been properly considered until now.

4.2. A Brief History of Hospitals

The places which are known as hospitals have evolved over time[83]. Perhaps, the starting point of such a history is in caves as the first places of human care. In the Neolithic era, what scholars, such as the architect Stephen Verderber, call 'sickhouses' were for healing the ill who were kept separated from the rest of community. In that time, the 'sickhouses' in Europe were organised on the basis of discrimination and segregation from the rest of society of the insane, ill, poor and disenfranchised people (Verderber 2010: 10). By the time of the civilisation of ancient Greece, however, the treatment of patients was considerably enhanced. In their tradition of healthcare, the environment had a significant role in causing sickness as

[82] Factors such as this are called 'conversion factors' in the literature. See for example, Ingrid Robeyns (2003 & 2005).

[83] The aim of this section, is mainly to show some important steps which have shaped the environment of hospitals over time. For this purpose, I will briefly describe some functions and conditions of hospitals (mainly in Europe) in different eras. I am not going to compare the conditions of hospitals between different regions or countries, even though the given examples of hospitals will be from various nations.

well as in healing patients. Such a belief in the relation between the environment and human health can be seen in Hippocrates' writings. For instance, he says:

> Whoever would study medicine aright must learn of the following subjects. First he must consider the effect of each of the seasons of the year and the difference between them. Secondly he must study the warm and the cold winds, […]. Lastly, the effect of water on the health must not be forgotten (Lloyd 1983: 148)[84].

Asklepieion (Asclepius)[85] of Epidauros, built in Athens in the fifth century BC, exemplifies ancient Greek places for the care of patients, in which environmental elements were used in a sophisticated way. It had a double hall with natural ventilation and daylight. The building was near to the river and used fresh water from natural springs; waste from toilets was transferred off the site to another watercourse. Access to the natural environment also provided part of the method of treatment. To care for patients, therefore, caregivers tried to realise their desires in the form of environmental pursuits such horseback riding, regular bathing for a period of time, and even reading a book under the shade of a tree (Verderber 2010: 13).

Although the ancient Greeks were the first to start using rational medicine, Rome in the first century AD began to evolve medicine and treatment (Verderber 2010: 11). Such evolution was reflected in the medical environment as well. The invention of military hospitals and improvements in public health engineering can be considered as main examples of such developments (Loudon 1997: 39). *Valetudinarium*s – military hospitals – were established along the border of the nation wherein soldiers were treated so that they could return to battle. Similar to Greek Asclepieions, Roman military hospitals were stoas. These buildings had latrines with a sewer system to get rid of waste from the hospitals. The buildings benefited from a number of design characteristics such as an open–air courtyard at the centre with a kitchen, as well as private rooms (Thompson, Goldin 1975: 4 – 6). However, over time, with the decreasing power of the Roman state, the Catholic Church became supreme in the delivery of healthcare with the focus on faith as a way of redemption and salvation. At this point, the natural environment loses its importance relative to that of religious belief (Verderber 2010: 17).

The purpose of places called 'hospitals' (*hospitale* in Latin) in the medieval era, specifically in Europe, was mainly to provide forms of *care* for those who needed it, rather than specifically medical *treatment* for those who are ill. Accordingly, the functions that hospitals had were related to the kind of service of care they gave to the people who needed such care. In this

[84] See also Lloyd (1983: 100, 126 – 127 & 246 – 248).

[85] In ancient Greece, Asclepius was identified as the god of medicine (Beech 2016).

regard, hospitals emerged with four primary functions, namely: leper houses, alms houses, hospices to provide 'hospitality' for wayfarers and pilgrims, and institutions for the care of the sick poor (Carlin 1989: 21)[86]. The major type of these hospitals were alms houses, and interestingly, only a few hospitals rendered care for the sick poor (Carlin 1989: 23 – 24)[87]. The provision of care services, however, even in these few hospitals "became an unwelcome and impossible burden" (Carlin 1989: 25). For instance, the hospital of St. Nicholas, Salisbury was founded in the thirteenth century to care for the poor sick and provide accommdation for travellers; however, by 1478, it became only an alms house (Knowles, Hadcock 1971: 389). It is also important to notice that what we call care service in these hospitals, was not professional care by physicians. What the poor sick could expect from such hospitals was only a bed for rest, warm and clean provisions plus sufficient diet (Carlin 1989: 31, Rubin 1989: 51).

In 1479 John Don, a mercer, made a bequest for a surgeon, Thomas Thorneton, to work for the next five years in a London hospital (Rawcliffe 1984: 8). The historian Martha Carlin states that this is the only evidence she could find for the "explicit provision of professional care for the sick poor" before the sixteenth century in England (1989: 30). The physical arrangement of medieval English hospitals in this period was different from the Roman one:

> Most contained or comprised an enclosed precinct, the access to which was controlled by one or more gates. The infirmary was built as a long, rectangular hall, like the nave of a church, which it sometimes was called. Usually there was a chapel or chapels at the eastern end of the infirmary hall, so that the patients could witness the daily celebration of mass from their beds. […] The accommodation for a hospital's staff, religious and lay, was separate from that of the other sick or other inmates. Almspeople, if resident, might share the infirmary or a common dormitory or dormitories, or might inhabit individual chambers; travellers seem usually to have been lodged with the sick in the infirmary (Carlin 1989: 28).

At the beginning of the second millennium, hospitals were mostly directed by the Catholic Church. The main function of the hospitals by 1348 (i.e. the era of the Black Death) was to provide accommodation, food and care for the poor through a number of (mostly) small charitable institutions (Henderson 1989: 69). From the second half of twelfth century to early thirteenth century, there was an increase in the number of established hospitals in the form of

[86] In some cases, hospitals provided moneylending services as well (Rubin 1989: 48).

[87] For more information about the nature and role of hospitals in England and Wales in this period see "Medieval religious houses: England and Wales" by Knowles & Hadcock (1971).

charitable institutions. This age witnessed a growth in the development of urban civilisation which included an increase in the number of charitable institutions such as hospitals. However, after the Black Death, donors focused on the development of *medical* hospitals. In addition, the increase in the wages of people after the Black Death helped to encourage an improvement in the facilities and the services in the hospitals. Hospitals in Florence were significant examples of such marvellous institutions with deliberate and dignified medical services. Luther, for instance, described a Florence hospital as a "regal building, with the finest food and drink, attentive service, very learned physicians and clean beds" (Friedenthal 1970:78).

After that time hospitals benefited from more professional doctors and surgeons. For example, it is documented that in the sixteenth century, the physicians of the San Giovanni hospital in Italy, had a practice of visiting their patients twice a day. There were also young surgeons, resident in the hospital, to control the progress of disease and report it to the chief physician (Cavallo 1989: 110 – 111). Gradually, hospitals found a new function – that of teaching – and in the eighteenth century gaining experience in hospitals became a mandatory precondition for medical students (Cavallo 1989: 111). The motivation for establishing hospitals should also be noticed. Before the late eighteenth century, the philanthropic stimulus of the layman was the main reason for establishing hospitals. In Britain, a new approach was taken when medical men started to run specialist hospitals. From the last third of the eighteenth century, medical men began founding their own outpatient dispensaries which gradually developed into specialist hospitals (Granshaw 1989: 201 – 202).

The First World War was to greatly boost the attraction of specialist hospitals. But well before then the advantages of such hospitals were seen not only in more specialisation in medical treatment, but also in the advancement of medical science through more textbooks, articles and new procedures (Granshaw 1989). The specialist hospitals, correspondingly, entailed new expectations in terms of their *design*. Analysing children's hospitals, for example, Carl Rauchfuss, a German–Russian paediatrician in 1877 said:

> If one were simply to build children's hospitals along exactly the same construction and with the same furnishing, equipment and organization as the general hospitals, then it would not be worthwhile building them at all; it would then be advisable to recognise the appropriateness of expanding on the practice of many already established general hospitals of treating sick children in a children's ward. The requirements of a children's hospital are, however, more complicated than those of a general hospital, and these incorporated children's wards are compelled under the circumstances to do without (quoted by Seidler 1989: 189).

Thus, running specialist hospitals not only affected the specialisation of medical treatments but also impacted on the design of hospitals. Subsequently, potential risks and threats for these hospitals started being detected. For example, infection was the main problem for sick children which led founders to separate out such institutions and create isolation houses as a new trend in building children's hospitals (Seidler 1989: 190).

Financial difficulties should be also considered as a factor that has affected design issues in the historical development of the hospital. As mentioned before, the main theme in the establishment of hospitals in the past was to support the poor. But in the course of the modernisation of hospitals in the twentieth century, the funds provided by charity were not sufficient any more. Therefore, hospital managers – particularly in those countries where medical service is not funded by the state, such as the US – tried to attract the middle–class into their hospitals so that they could make up the shortage in funding (Vogel 1989: 247).

In this context, then, it is expected that the patients' interests and satisfaction become more important than before. Therefore, regardless of the importance of what we might call the moral interests, needs or condition of patients, this parameter becomes crucial as a marketing characteristic in which patients are seen as the hospitals' customers. Accordingly, the satisfaction of patients through hospital design is now a substantial imperative, and hospital designers cannot simply create a hospital as a place wherein curing occurs. The satisfaction of patients delivered through the environment of hospitals should be taken into account as an essential parameter which can increase the overall satisfaction of people in the hospitals.

Thus the shape of medical environments, and particularly hospitals, is something inherited; a heritage that has developed over time. What I have sketched above is only a brief explanation of the history of hospitals, focusing particularly on European hospitals. Obviously, the history of medical buildings has many other stories to tell, especially if we consider other regions and nations. However, I have tried to show the way in which the evolution of medical services formed our medical environments; from stoas in ancient Greece, and cruciform structures in the medieval age, to what we know today as the hospital. Our current expectations of hospitals are affected by such historical developments - although other parameters also have a role in determining these expectations. One such parameter is our modern understanding of dignity and entitlements; an understanding that should have a greater and more precise role.

Although the current approach to the design of hospitals is something that has developed over time, there is a need for rethinking both this approach and its associated trends. In the traditional approach to hospital design the focus was only on "functional efficiency, cost, and providing effective platforms for medical treatments and technology" (Ulrich 2000). A modification of this approach has recently begun: patients are now being put at the centre of

considerations in hospital planning. Such a patient–centred approach, which is called Evidence–Based Design (EBD), uses the findings of studies concerned with the positive impact of environmental elements on people in hospitals[88].

However, EBD is not yet known of globally. Therefore, the effects of the hospital environment on patients are not properly considered in many cases of design. Moreover, owing to its strategy, EBD by itself cannot guarantee an inclusive ethical environment. In section 4.8., I will analyse EBD and explain why this approach to hospital design cannot comprehensively respond to the rights of people in hospitals and how, therefore, the design of many hospitals does not sufficiently address the non–medical demands of people (e.g. the ethical needs of patients, visitors and staff). As a result, people are still experiencing many difficulties while they stay in hospitals.

4.3. Stop Worsening, Start Enhancing

As we have seen[89], one of the central concepts in the Capabilities Approach is the notion of 'thresholds': the levels which determine whether or not a person needs help to live a life worthy of human dignity. Thus, to meet the responsibility towards the dignity of people, what is essential is to focus on the condition of people who are either below, or in danger of falling below, these thresholds, because *this is the condition in which others have a duty to support the dignity possessors.* Analysing such conditions plays a key role in finding the ethical principles for hospital designers. In terms of hospitals, we should consider the capabilities of those who can fall under the thresholds and how they can do so. The capabilities of different parties in hospitals can fall below the thresholds, but patients are always at the centre of this peril. For example, the bodily health capability of patients is more or less impaired and, because of that, they go to the hospital so that they can be treated (i.e. so that their bodily health capability can be improved up to the thresholds).

Similarly, some of the capabilities of the family and relatives of patients are also threatened (e.g. capabilities of bodily health, emotions and affiliation) when they are suffering, for instance, from stress or anxiety. The stressful and demanding jobs of medical teams can also cause several problems, such as fatigue and injury, that can be considered a reduction in capabilities. All in all, most people in hospitals are at risk of a reduction in the level of their capabilities. Since the result of such a reduction is in many cases to go below the thresholds,

[88] For more discussion of EBD see section 4.8.

[89] See chapter three, section 3.1.3.2.

designers have an ethical responsibility to ensure that the hospital environment can facilitate protecting people from such harm (if it is avoidable) whilst also sufficiently supporting any harmed capabilities. Being below the threshold of those capabilities whose level can be *changed by the environment of the hospital* will be called '*harm*' in this thesis. Therefore, the ethical principles should address the harmed people and the condition in which people may be harmed.

The capabilities of people in hospitals might be (or become) below the thresholds for different reasons. However, since our focus in this thesis is on the environmental impact of hospitals on people, when discussing 'harm' in this chapter we are only concerned with those kinds of harms that the hospital environment can affect. Hence, the harms mentioned in this thesis do not include those kinds of harms which people may suffer in hospitals by other means such as staffing shortages and the like, *unless* the environmental condition can reduce or increase the risk of those harms[90].

Having this clarification, we can hold that there will be no (environmental) harm if the hospital designer has fully met her ethical responsibilities. This is because, on this account, morally designed hospitals have an environment in which harm is removed or mitigated as much as possible by the designer(s). In other words, hospital designers are not responsible for any and all kinds of harm (in a general sense) in such hospitals, because they can do nothing more than what is required of them in the original design of the hospital. For example, a patient who has broken her leg and is hospitalised in a morally ideal hospital might still endure pain for a while. We will not consider such kinds of harm (e.g. the pain of the broken leg) as the designer of the hospital has done all that she could in order to reduce the pain of patients, through the use of the tool of the hospital environment. Accordingly, the ethical principle should be able to *direct* designers to build hospitals wherein either there is zero (environmental) harm or the harms are reduced as much as possible.

This goal can be achieved if hospital designers focus on two main missions. Firstly, to prevent a person's condition from deteriorating and, secondly, to attempt to make it better. In other words, a designer needs to be aware of how the environment of the hospital can prevent people from a further decrease in their capability levels. Furthermore, in his designing he should aim to help restore the already reduced capabilities and so help the individual to enjoy their basic

[90] Medical errors, for example, are mainly caused by human error or equipment faults. However, the hospital environment can also affect these kinds of harms (i.e. can positively or negatively affect the risk of these errors). Therefore, even though these kinds of harms are not directly caused by the environment of hospitals, they are relevant to my arguments given that the design of the hospital can affect them.

entitlements by removing or decreasing the effects of inevitable harms. In short, the ethical principles should *stop worsening and start enhancing people's capabilities.* In this light, I am going to suggest the following three ethical principles for hospital design: design for vulnerability, design for healing and design for reverence.

4.4. Principle 1: Design for Vulnerability

4.4.1. Vulnerable People

> When people are in crisis they are at their most vulnerable. It is essential that they receive the care and support they need as quickly as possible, in a place they can feel safe, and that they are supported by people who understand their needs (Care Quality Commission, 2014: 2).

In chapter three, I explained the importance of respecting one's own dignity[91]. I mentioned that in normal circumstances human beings strive to develop their capabilities and provide for them, perhaps in many cases beyond the thresholds. Therefore, while a person is in a normal situation, particularly while he is healthy, he would usually enjoy his own capabilities to the extent that he is able to. However, when people find themselves in crisis, such as may be produced by serious illness or accident, they become vulnerable. This is because they may lose their concentration and/or ability to focus on their capabilities, and consequently, they cannot provide for their capabilities by themselves unless others support them to make up for their disability.

Thus, they are vulnerable in this situation owing to the fact that their dignified life is contingent upon the support of others, and there is a risk that others will fail to duly provide for them. In fact, they may easily suffer profound insults to their dignity, if not lose their life, if others neglect their vulnerable situations and their need for help. This is what the Capabilities Approach emphasises. Seeing the dignity of human beings as bound up with their vulnerable embodied animality and need for support from their society, in fact, is one of the characteristics of the Capabilities Approach which makes it different from the Kantian approach:

> […] we [who support the Capabilities Approach] build in an acknowledgement that we are needy temporal animal beings who begin as babies and end, often, in other

[91] See section 3.1.4.1.

> forms of dependency. We draw attention to these areas of vulnerability, insisting that rationality and sociability are themselves temporal, having growth, maturity, and (if time permits) decline (Nussbaum 2006: 159).

Undoubtedly, the condition of people in hospitals, particularly for patients, is one of the important instances of being in a vulnerable situation. People in hospital are vulnerable to many harms which threaten them. A patient who is in danger of being a victim of medical errors, falling on the floor, being infected by polluted surroundings, and many other potential harms, can suffer serious assaults on her dignity far more easily if other parties in the hospital neglect her vulnerability. Other people (e.g. relatives and staff) are also more or less at risk of suffering potential harms. All in all, the condition of people in the hospital environment makes them vulnerable to various forms of harm.

This is one of the reasons that we can see the concept of *vulnerability* considered in the context of healthcare service, as one of the features of humanity which leads to an ethical responsibility to protect people (Kottow 2004: 282). The notion of vulnerability has an essential status in the field of bioethics. As mentioned in chapter two, this concept, has even been suggested as one of the main ethical concepts in bioethics (Rendtorff 2002). In the Barcelona Declaration (November 1998), which was "a philosophical and political agreement between experts in bioethics and biolaw from many different [European] countries", the concept of vulnerability is articulated as follows:

> Vulnerability expresses two basic ideas. (a) It expresses the finitude and fragility of life which, in those capable of autonomy, grounds the possibility and necessity for all morality. (b) Vulnerability is the object of a moral principle requiring care for the vulnerable. The vulnerable are those whose autonomy or dignity or integrity are capable of being threatened. As such all beings who have dignity are protected by this principle. But the principle also specifically requires not merely non interference with the autonomy, dignity or integrity of beings, but also that they receive assistance to enable them to realise their potential. From this premiss it follows that there are positive rights to integrity and autonomy which grounds the ideas of solidarity, non–discrimination and community (Rendtorff 2002: 243).

However, Cunha & Garrafa think that bioethical approaches towards vulnerability are not the same across different regions:

> As we have noted, in bioethics originating from the United States, vulnerability is usually correlated with incapacity to provide consent or to exercise autonomy, whereas in European bioethics the focus is mostly on the condition of intrinsic frailty

> of all living beings. From the Latin American perspective, the discussion is characterized by a political focus aimed at identifying the ways in which vulnerabilities are produced and exploited, along with vulnerable individuals themselves (2016: 204).

However, such different approaches towards the notion of vulnerability have not undermined the importance attached to it in medical contexts by universal documents, such as the Universal Declaration on Bioethics and Human Rights:

> In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected (UNESCO, 2005: Article 8).

Thus, considerations of vulnerability are held to play a key role in shaping the quality of medical services. Accordingly, hospital designers, who are a provider of medical environments, cannot oversimplify this notion in their work. But, how should it be defined in a way that is consistent with the context of hospital design? According to the Oxford English dictionary the meaning of the notion of 'vulnerability' is being "exposed to the *possibility* of being attacked or harmed, either physically or emotionally" (Stevenson 2010, emphasised by me). In other words, a vulnerable person is in danger of being harmed, even if he has not yet been harmed. Hence, it would be true to say that vulnerability warns us about the *potential harms* which threaten vulnerable individuals.

What is meant by the concept of 'potential harm'? Potential harms are those kinds of harm that *might* occur such as falling on the floor, medical errors, and the like. Studies show that a well-designed hospital can decrease the risk of such harms[92]. Thus, the concept of 'potential harm' conveys the sense in which although harm may not yet have happened, people in the hospital environment are still at risk. This is similar to the sense in which we have understood the notion of 'vulnerability'. Therefore, if one says that a designer ought to consider the vulnerability of people in hospital design, this is similar to saying that the designer is called on to act against potential harms. Therefore, I suggest *'design for vulnerability' as one of the ethical principles of hospital design*.

As mentioned above, the concept of vulnerability is defined differently. However, it is important to notice that what we are defining as the principle of design for vulnerability should be considered in the context of the discussion given thus far in this thesis – i.e. we are

[92] See section 3.4. and 4.4.2.

concerned with vulnerability in the hospital environment. This principle refers to harms in terms of the hospital environment: the potential harms which can be removed or alleviated by hospital design. For instance, using appropriate material can ensure that the floor is less slippery and, accordingly, the risk of falling on the floor will be decreased. These are the sorts of recommendations that the principle of design for vulnerability will suggest to designers.

I have used the notion of 'vulnerability' in order to identify a principle that can help to bridge the ethical concerns of hospital design and bioethics, but it should be noted that the essence and the implications of vulnerability can be different in biomedical contexts. For example, the European notion of vulnerability, as quoted above, implicitly refers to all kinds of harm a patient may suffer during the process of care. In contrast to this, the principle of design for vulnerability only aims at potential harms which might occur; and not those harms which we expect to see in hospitals, e.g. pain, stress, and the like[93]. It is also worth emphasising that the principle of design for vulnerability considers everybody who uses the hospital environment, whether as a patient, a relative, a member of staff, or a visitor.

Hence, the principle of design for vulnerability asks designers to consider all potential harms which people may suffer, and to endeavour to find suitable elements of design that can prevent such harm (or at least make their occurrence less likely). The concept of vulnerability, given the above explanation, can remind a designer of the fact that the capabilities of people in hospitals are in danger and lead her to use elements of design that can minimise further harms (further harms in the sense that such harms are not inevitable and, therefore, if they do occur then some *further* harms have been imposed on people, which indicates a worse situation for them). This principle represents the ethical mission of 'stopping capabilities from worsening'. Hence, design for vulnerability is a principle that protects people from being in a worse situation in hospitals[94].

4.4.2. Vulnerability in Hospitals

There is an important issue which should be considered before I continue the arguments of this section. There are many studies in which it is shown that the hospital environment can positively/negatively affect the process of care and the condition of people in hospitals.

[93] In the following sections, I will suggest two other principles of hospital design which deal with the other sorts of harm.

[94] The other part of a designers' mission – i.e. the enhancement of capabilities – will be addressed by two other principles which I will discuss in the following sections.

However, there is no systematic argument or method that fully considers the ways designers can address their ethical responsibilities towards patients and others in hospitals. In this respect, this research is the beginning of this discussion in this field. What we have at the moment is an ample amount of research in which the effects of different elements of hospital design on people is discussed; but there are no ethical arguments to help us advance the implications of these principles in practice, such as what we have in bioethics. Medical ethics has a long history and the ethical dilemmas related to this field (e.g. abortion, euthanasia, decision and consent, and so on) have been discussed in detail and considered in the light of various philosophical theories and approaches. However, a similar background of argument is missing in the field of hospital environments.

As we have seen, the history of the hospital shows that in the beginning such places were considered only as places in which poor patients were hospitalised, and only gradually did they become places in which treatment occurred. But, apparently, there was no serious concern for the condition of people in hospitals, until recently. These days, the 'satisfaction' of patients is considered, and designers attempt to build a pleasant environment. However, as was mentioned[95], the appeal to satisfaction and its implications basically starts with a concern for the hospital budget, rather than patients' entitlements. Therefore, instead of having arguments discussing the ethical responsibilities of hospital designers, we have discussions concerning how the elements of the hospital environment can satisfy patients or enhance medical outcomes. Therefore, there are no considerable ethical arguments in the field of hospital design with which I can examine the abilities of my suggested principles.

However, having established the ethical principles for hospital design, I believe that this field (i.e. ethical arguments concerning the hospital environment) can proceed, as it now has a theoretical platform – i.e. what I am trying to establish in this thesis. I hope that future researchers work on this field even further, and discuss the implications of the ethical principles of hospital designers in different cases of design. It is possible that they might suggest better principles for hospital design than mine. However, at least for now, these principles can help us to begin to have an ethical discussion in this field. Nevertheless, although we are empty-handed in terms of ethical arguments, we have plenty of studies about the effects of different elements of the hospital environment on people. Therefore, what I can do for the time being is show how these ethical principles can lead designers to think about those sorts of harms in hospitals. I will also argue that if designers do not consider my

[95] See section 4.2.

suggested principles in their references to those studies, the risk of failing to address the ethical requirements of people in hospitals will increase[96].

In this section I would like to deal with the first task of showing how the principle of design for vulnerability underscores the vital potential harms in hospitals; harms that can be removed or alleviated by the design of the environment. Vulnerability can be seen among different groups of people in hospitals (e.g. patients, relatives, and staff) and in various forms (e.g. bodily, mental, and even ethical[97]). Patients in particular are vulnerable in many respects, of course. There are many threats in hospitals which can harm patients, some of which can even end in the death of patients. Dying because of medical errors, which in many cases are preventable, can be considered as losing the capability of life:

> Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7 percent of hospitalizations, respectively. In Colorado and Utah hospitals, 6.6 percent of adverse events led to death, as compared with 13.6 percent in New York hospitals. In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented. When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors. The results of the New York Study suggest the number may be as high as 98,000 (Kohn, Corrigan et al. 2000).

In another study, the rate of death from medical errors is estimated more than 250,000 a year in the US hospitals, which means "medical errors is the third most common cause of death in the US" (Makary, Daniel 2016).The Institute of Medicine has stated that the health care service in the USA "harms patients too frequently and routinely fails to deliver its potential benefits" (Institute of Medicine (U.S.), 2001: 1). In this regard, patients in hospitals are vulnerable to loss of the capability of life due to medical errors. This is because Nussbaum has defined the capability of life as:

> *Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living (Nussbaum 2006: 76).

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[96] See section 4.8.2.

[97] In chapter three, section 3.1.4.1., I explained that some people may lose their ability to respect their own dignity. Human beings may find themselves unable to provide for their own capabilities, and thus, they are ethically vulnerable.

Besides losing the capability of life, some other capabilities may be harmed as well. The capability of bodily health can go under the thresholds if medical errors causes a serious bodily problem, or exacerbate the patient's disease. However, the victim of medical errors are not only patients necessarily. It can be imagined that in an event of medical error the morally sensitive physician may feel guilty for not sufficiently caring about his patient – i.e. harming the capability of affiliation and emotion. But the most important point for designers is that the environment of hospitals can indirectly reduce the risk of medical errors in many ways. For example, transferring patients between rooms can increase the risk of medical errors. In this regard, research by Hendrich and her colleagues, shows that by providing acuity–adaptable rooms the rate of medical errors will be reduced considerably (2004).

Infection is another essential example of potential harms in hospitals to which people are vulnerable. According to one study of healthcare–associated infection in 183 hospitals in the USA the number of patients who were affected was 452 in 2014 (4% of all patients) (Magill, Edwards et al. 2014). This rate compared with 9% of patients who were infected during their stay in UK hospitals in 2000; that is, at least 100,000 infections a year which cost one billion pounds a year for the NHS (Kelsey 2000). However, it is important to notice that 10% to 70% of infection rates can be prevented (Harbarth, Sax et al. 2003). Therefore, infection should be considered as a potential harm.

Infection can be considered as impairing the capability of bodily health; in some cases, as reported above, it ends in death which is loss of the life capability. Therefore, everybody should strive to decrease the risk of infection among patients in hospitals and this can be interpreted as a form of respect for human dignity. Nevertheless, it should be noticed that the problem of infection is not an inevitable situation which every patient will suffer from; it is a potential risk for vulnerable patients in hospitals. Thus the principle of design for vulnerability can lead designers to protect patients from infections by emphasising (at least) patients' capabilities of life and bodily health in hospitals.

Interestingly, studies have shown some environmental elements of hospital design can protect people from infections. HEPA filters, for instance, can considerably reduce the risk of air infections in the hospitals (Passweg, Rowlings et al. 1998, Sherertz, Belani et al. 1987). Direct contact with other people in hospitals is also a principal pathway for the transmission of infections to patients (Bauer, Ofner et al. 1990). Larson (1988) has counted 423 articles between 1879 and 1986 which all confirm that hand–washing can reduce the risk of infection in hospitals. Therefore, suitable positioning and sufficient number of hand–washing sinks in hospitals can have an effect on the reduction of the rate of contact infection. This is an obvious

example which shows how the principle of design for vulnerability can, in practice, direct designers in protecting patients from a loss of capability.

Nonetheless, it should be noticed that infection does not only threaten patients; hospital staff are also at a high level of risk of being infected (Jiang, Huang et al. 2003, Kromhout, Hoek et al. 2000, Kumari, Haji et al. 1998, Smedbold, Ahlen et al. 2002). Thus, the principle of design for vulnerability will also draw the attention of designers to this potential harm to staff. And again, they can address this requirement as well, because the environment of hospitals can also prevent staff from such harm; for instance, by providing suitable ventilation in hospitals (Menzies, Fanning et al. 2000). Hospital staff are also vulnerable to being injured during their work, as another example of potential harm. Accordingly, design for vulnerability invites designers to consider the best plan which can reduce the risk of staff injuries. For instance, a study has shown that the ergonomic redesign of a hospital (which involved modifying the toilets and shower rooms), resulted in the medical staff experiencing less back strain in comparison with the condition of the hospital before redesigning (Garg, Owen 1992).

Patients' relatives are also vulnerable in hospitals, and hence, design for vulnerability can protect relatives as well. For instance, parents of sick children may suffer from severe stress and anxiety for their child. Although some of the causes of stress may be considered as inevitable, some other environmental causes of stress may be counted as a potential harm, such as unpleasant odours and air pollution (Hasan Tehrani, Haghighi et al. 2012). These can be removed or alleviated by a well–designed hospital (e.g. by proper ventilation). Another example of potential harm to families in hospitals is a confusing design of wards and corridors which can cause disorientation and waste of time. Difficulty in finding different parts of a hospital can exacerbate the stress of family when they wish to visit their relative promptly.

I have just mentioned some well–known instances of potential harms the risk of which a suitably designed hospital can reduce. However, this does not mean that the principle of design for vulnerability should only deal with instances that have been the subject of studies thus far. We need further research to investigate how the other basic entitlements of people, as suggested in the previous chapter, can be threatened by the environmental elements of hospitals. Subsequently, we will need to discover in which ways designers can remove (or decrease the risk of) those harms. For example, we know that medical errors can deprive patients from their basic entitlements and, as was mentioned, it is more or less clear for designers how they can reduce the risk of those harms. We need to do the same in terms of other unknown potential harms, in order to discover how designers can protect people's entitlements. This is how the ethical principles can be used to enhance the ethical conditions of people in hospitals.

This also means that hospital designers should be guided by these principles in order to identify the conditions of people and the elements of design which can cause or reduce harm. Therefore, these ethical principles should be considered in each case of design, and should be followed by designers regarding any ethically relevant condition (regardless of whether or not that condition and its relation to the quality of care has been investigated). Thus, for instance, if the designer of the hospital mentioned in the first chapter[98] had been told that one of his ethical principles is to design for vulnerability then he might have provided a private corridor so as to protect the patient from public–viewing. Of course, this does not mean that designers should overlook the findings of studies; what I am emphasising here is the importance of not ignoring the ethical requirements of people in hospitals when there is no available research about them.

In short, all groups of people in hospitals are at risk of suffering from potential harm. Hospital designers, then, have an ethical responsibility to consider people's vulnerability because several studies have shown that the environment of hospitals can prevent people from such harm. That is the reason that the principle of design for vulnerability, which addresses potential sources of harm in hospitals, should be seen as a main ethical principle for hospital designers. This principle encourages moral designers to keep asking themselves how the environment of the hospital can prevent such avoidable harm, and guides them to use relevant elements in their design to protect people from potential harm. Designers should think about vulnerable situations and conditions of human life in hospitals and try to prevent any further reduction in the capabilities of people. Design for vulnerability is a principle which protects people from the worse situation in hospitals. The given instances above clarify how the principle of design for vulnerability can lead designers to meet their ethical duties by using the proper elements of design in terms of vulnerability.

4.5. Principle 2: Design for Healing

4.5.1. The Healing Environment

The main function of hospitals is healthcare service. Therefore, the purpose of going to a hospital is usually centred on the concept of *healing*; whether it is a patient who wants to be healed, medical teams who want to heal patients, or relatives who wish that the patient be

[98] In which I witnessed an embarrassed patient being carried through a public corridor while covered insufficiently with only a gown (see section 1.1.).

healed. Accordingly, it is expected that the ingredients of hospital environments serve the delivery of healthcare and the healing of patients. As mentioned already[99], the main theme of traditional approaches to providing a medical environment was to build a place in which medical service is possible. Hence, the environment of hospitals was provided as a place that facilitates the treatment of patients. In many places this approach has not yet changed. Because of this, "people expect treatment for physical or mental illness in hospitals, but rarely anticipate spiritual, emotional, or social healing" (Gesler 2003: 83). However, studies have shown that the hospital environment can contribute to the process of caring for patients and the well–being of people in hospitals. This has caused a newer approach in hospital designing which tries to consider the environmental elements of hospitals as part of the treatment of patients. Nevertheless, the effect of hospital design on patients is not the only issue; the condition of the hospital staff and the families of patients can also be enhanced in a well–designed hospital[100].

Therefore, there is a considerable emphasis on providing a 'healing design' which sees the function of the hospital environment beyond being merely a place for treatment. In this light, it is not surprising to see that there are a number of research findings written up with headings about healing design, such as 'healing environment', 'design for healing', and so forth. However, considering these studies reveals that there is no unity in the understanding of the concept of healing design. Some authors describe the healing environment with notions close to the sense of a therapeutic environment[101], but some others equate the features of a healing environment with medical outcomes or the concerns of EBD[102]. If we see the healing environment merely as a matter of being a therapeutic environment, then we would focus on the treatment of patients in hospitals. However, if we understand the function of the healing environment in its broader aspect then it can include a sense of well–being for everybody who uses the environment - including patients, staff and relatives. From this perspective, the environment of the hospital can facilitate the removal (or at least the mitigating) of a harm for which people go to hospital, whether it is pertinent to bodily health capability, capability of emotion, affiliation or any other capabilities. Since facilitating the removal of harms is expected from hospital designers, this sense of design for healing should therefore be a part of

[99] See section 4.2.

[100] Find some impacts of hospital environment on people in sections 3.4. and 4.8.1.

[101] See, for example, Raz Gross et al. (1998), and Rachel Long (2001).

[102] See, for instance, Huisman et al. (2012), C. Robert Horsburgh (1995), Nina Ergin (2015), and Jaynelle F. Stichler (2008). To know more about EBD, see section 4.8.

the ethical mission of hospital designers. Hence, we should be able to find a definition of the concept of healing compatible with what is discussed in the Capabilities Approach.

The ethical principle of design for vulnerability, which targets the potential harms of people in hospitals, was discussed above[103]. However, there is another sort of harm which can be expected to *definitely* occur in hospitals - particularly if the entitlements of people are not considered (e.g. pain, stress, fatigue). Designers, in addition to deterring potential harms, have a responsibility to provide an environment that can facilitate the enhancement of harmed capabilities. This is the second part of the main mission of hospital designers (i.e. stop worsening and start enhancing) mentioned earlier. By completing these two parts of their mission, designers can ensure that they have met their ethical responsibilities.

Some of these expected harms are an inevitable part of the reason people go to hospitals. People go to hospitals for different purposes; patients go to hospitals to be treated; families go to hospitals to be with their relatives and support them; staff go to hospitals to work. The level of the capabilities of people in hospitals may decrease because of activities and conditions which are inherently related to their purpose in being there. For example, the bodily health capability of patients has fallen (i.e. is harmed) because of their disease or accident. They may also keep suffering from the harm when they are in hospital (i.e. whilst they are not completely cured). Even a patient who experiences pain after her surgery is suffering from harm that is related to a part of the process of her treatment (i.e. surgery). All these instances, alongside many others, are examples of a sort of expected harm that is inevitably related to the purpose of going to hospital.

Medical staff who, for instance, experience stress in their job are also suffering from such purpose–related harm. This is because their purpose for being in the hospital is their work or career; and such stress is a result of that work or their pursuit of that career. Likewise, relatives in hospitals may suffer from purpose–related harm. Their purpose or reason for being in the hospital might be to support their friends or family during treatment. This purpose can involve them experiencing stress and anxiety about the condition or future of their ill friend or relative, for example. These are a few instances that show how people may find their capabilities impaired or undermined for reasons related essentially to their purposes for being in hospitals.

As explained previously, the purpose for which people go to a hospital more or less centres on the notion of healing. Furthermore, as previously mentioned, this concept in its broader meaning can convey a sense of striving against not only harm to bodily health capabilities, but also harms of other capabilities such as emotion, affiliation, play and the like. Therefore, we

[103] See section 4.4.

can say that the concept of healing in hospitals can inspire a sense of acting against the harms which are related to the purposes people go to the hospital. I would like to take advantage of this sense of healing in my thesis, and suggest *the principle of 'design for healing' as the second main ethical principle of hospital design*, by which hospital designers are directed to consider the purpose-related harms.

The ethical principle of design for healing encourages hospital designers to improve the environment of the hospital so as to protect or enhance the capabilities of people who have suffered from purpose–related harms. The main theme of this principle, thus, is related to the function of the hospital (i.e. healthcare service). The principle of design for healing, therefore, mostly invites designers to consider the environmental elements which can support the healthcare service. Such elements can support the healthcare service in different ways. In one way, hospital designers should attempt to facilitate the process of care for medical staff. They need to identify how the hospital environment can give practitioners the opportunity to effectively treat patients, and then provide for that opportunity. A suitably designed theatre with sufficient support for equipment can ease operations for surgeons, a proper layout of an ICU with a sufficient view to all beds can give more control to the nursing station.

Appropriate design to enhance the quality of care and ease the medical service for staff in the light of the principle of design for healing, can be considered as a matter of acting against purpose–related harms for at least two groups of people in hospitals. The first is the medical staff who have to serve the patients. If the hospital environment is designed in a way that medical teams find working there easy, fast, and safe, they will experience less purpose–related harm, such as fatigue, stress, and so on. For example, if nurses in an ICU can see easily all their patients from their station, they probably have more time to rest there, in comparison with nurses who work in a badly designed ICU that requires them to frequently move around that unit to ensure everything goes well.

Undoubtedly, the main people who benefit from a high quality of care are patients; if the design of hospitals can affect the quality of care, the purpose–related harm of patients (i.e. their disease and its symptoms), will be removed more effectively. If we see such facilitating of the environment of hospitals from the viewpoint of its benefits for patients, this kind of design would be action against purpose–related harms of patients in an indirect form of respect; the hospital designer provides a suitable environment for medical teams, in order to respect the dignity of patients so that they can meet their thresholds of their entitlements. All in all, the principle of design for healing can guide designers to eliminate (or alleviate) such purpose–related harms by encouraging them to provide as much as possible a convenient

environment for treatment of patients in which medical service is easy, well–equipped, fast, and safe.

In addition to providing a handy environment for healthcare service, as studies have demonstrated, designers should notice that the environment of hospitals itself can actively contribute to the process and quality of care. For example, it can cause a reduction in the level of stress, help for faster recovery, lessening of pain and so forth[104]. Hence, by considering such ethical elements in their design, planners can directly respect the dignity of patients by contributing towards an improvement in the level of patients' capabilities. Therefore, the ethical principle of design for healing invites designers to consider these therapeutic aspects of environmental elements and incorporate them in their planning. In short, the principle of design for healing leads designers to act against purpose–related harms firstly by providing an appropriate environment for the process of care, and secondly, by incorporating the elements of design which can positively affect the condition of people in hospitals.

It should be noticed that the concept of healing in this principle is linked to the purpose – related harms of the all people in hospitals, and it should not be mixed up with its common sense meaning (i.e. curing patients). Therefore, when a designer wants to apply the principle of design for healing in order to enhance the capabilities of staff or relatives, this would not be necessarily and primarily about the healing of patients, even though patients may benefit from such design as well. For example, the purpose of staff who go to hospitals, may be their work. Hence, some specific kinds of harms such as fatigue, work–related stress and the like are the purpose–related harms of staff; and accordingly the designer has to find out which elements of design can reduce the level of staff fatigue, for instance. Thus, the principle of design for healing, in terms of respecting the dignity of staff and relatives, is not about finding ways to heal patients per se, it is about a better environment for staff or relatives.

Another point that I have to emphasise is that even though the main function of hospitals is focused on the concept of healing (in common sense terms), a designer should remember that some hospitals have other functions as well (e.g. university hospitals). In the cases of university hospitals, therefore, the purposes of academic staff and students who go to the hospitals is not limited merely to the healing of patients, it also involves educational purposes. Accordingly, designing to address the purpose–related harms of these groups of hospital users, may demand some different facilities and elements of design.

[104] In section 4.8.1. some of these examples will be elaborated further.

4.5.2. Healing by Design

As with the previous section, I would now like to show how considering the principle of design for healing in a dignity approach can lead designers to identify their ethical obligations. For example, the pain of surgery can be seen as an instance of purpose–related harm, because surgery is a part of the process of care in some cases of treatment. The fourth central capability described by Nussbaum is the capability of senses, imagination and thoughts which insists on "being able to have pleasurable experiences and to avoid non–beneficial pain" (Nussbaum 2006: 76).

According to this definition of the capability, non–beneficial pain is something that undermines it and should be avoided. Although the surgery itself is supposed to be beneficial, the pain of surgery per se is an unpleasant source of harm which should be avoided (i.e. removed or at least mitigated). Therefore, undergoing pain after surgery is an instance of impairing the capability of sense, imagination and thought. Moreover, severe pain can threaten the other capabilities of patients as well. In the previous chapter[105], I explained how developing and exercising one's capabilities is crucial to respecting one's dignity by providing for the thresholds of one's own capabilities by oneself, provided that one can sufficiently concentrate on this duty and is able to act on it. The severe pain of patients can be seen as a threat to both of these two conditions (i.e. ability and concentration). For example, such a patient is probably not able to focus on his capabilities of play, control over his environment, and so on.

Therefore, the pain after surgery can be considered as a harm to a number of capabilities which is a case for the principle of design for healing. This means this principle leads moral designers to see how they can help to protect or heal any threatened capabilities by helping to reduce the level of the pain or making its period shorter. Such moral designers, then, cannot ethically ignore those studies which show that the environment of a hospital can alleviate surgical pain. Walch, et al., for example, demonstrate that the patients who undergo elective spinal surgery and are hospitalised in a bright room, required 22% less opioid–equivalent analgesic medications than those who are in dim rooms (2005). Another study has proved that patients who are accommodated in the sunny rooms stay 15% less time in hospital than others who stay in dull rooms (Beauchemin, Hays 1996).

Likewise, moral designers can consider other indirect ways of enhancing the harmed capabilities of people. For example, the environment of hospitals can positively impact the effectiveness of staff work, which would lead to better quality of care. Appropriate quality of care is that which effectively strives to enhance the patients' capabilities. Thus, by enhancing

[105] See section 3.1.4.1.

staff effectiveness, those capabilities of patients which can be protected and healed by hospital staff, would be indirectly enhanced. The principle of design for healing, therefore, encourages improvement in the quality of care. It highlights, for example, the study which showed that acoustic ceilings can reduce the pressure of work on staff (Blomkvist, Eriksen et al. 2005). Thus if a hospital designer designs for healing, the environment of the hospital will not only facilitate the treatment of patients for medical staff, but also the environment itself will help in the healing process by restoring or recovering damaged capabilities. Consequently, this principle supports designers to plan for the best possible place for healthcare service. In addition, this principle invites moral designers to see if there is any element that can contribute in the process of care, and incorporate it into the design of the hospital.

Again, although at first glance the concept of healing directs attention to the treatment of patients, the principle of design for healing, as explained in this thesis, concerns other people in the hospitals as well; whether this is families who suffer from anxiety and stress, for example, or staff whose work is stressful and exhausting. The principle of design for healing asks the designer to consider the condition of families in the hospitals and to ease their difficult situation. A moral designer, by this principle, would also pay more attention to the stress, fatigue and many other sources of harm which staff might experience during their work in the hospital. She would then attempt to find elements which can address these sources of harm in her planning.

4.6. Principle 3: Design for Reverence

4.6.1. Beyond Medical Care

Thus far, I have suggested two ethical principles: design for vulnerability and design for healing. The theme of both of these principles concerns seeing individuals in their particular medical-related context and then designing accordingly. There is no doubt that considering people in the context of their vulnerable situation in hospitals, as well as in their need for being healed in such medical environments, is an important ethical obligation of hospital designers. However, it is also necessary that designers do not merely provide for the health–related requirements of people in hospital, but that they also value their human status per se and consider the other entitlements of people that can be affected by being in the hospital; the environmental limitations which deprive people of their non–medical needs.

Patients in hospitals know that they are inevitably going to be limited by being in that environment: they will be at least relatively isolated from society while they are in the hospital; they cannot go outside and freely play or choose their activities; they cannot express their religious and cultural interests as freely as they did in their normal life. In many respects, the environment of hospitals can deprive people of their entitlements even when this is not a matter of their medical condition, but simply of being in such an environment. Therefore, there are other forms of harms which are caused by merely *being* in the hospital environment. I shall call these *environmental harms*, which can be removed or mitigated by a well–designed hospital. This indicates that hospital designers have an ethical responsibility to plan against such harms.

As instances of this sort of harm are not related to medical issues, less attention has been paid to them; perhaps this is because it is accepted that when one goes to a hospital one should expect to endure certain harms owing to the nature of being in a hospital. In this light, I think hospital designers need a principle to draw their attention to the fact that people in hospitals, despite medical concerns, have some general requirements and feelings as human beings. We require a notion to highlight the importance of this human aspect of people, in order to guard against merely focusing on medical-related aspects. It is essential to underscore the necessity of deeply respecting the valuable status of human beings. I suggest the concept of *reverence* to highlight the importance of this concern, as the Oxford Dictionary defines this notion as "a feeling of great respect or admiration for [somebody/something]" (Hornby, Turnbull et al. 2010: 1311).

I am going select the term 'reverence' to represent this ethical obligation of hospital designers, because this term can inspire designers to recognise that their responsibilities are continuous with very general human values and the notion of a 'decent life' (i.e. irrespective of the particular situation of a certain medical context). In this regard, I suggest *the principle of 'design for reverence' as the third ethical principle of hospital design,* the aim of which is to encourage designers to plan against environmental harms. The principle of design for reverence asks designers to identify the ways in which being in the hospital environment can reduce the level of capabilities of people, and then to attempt to remove or decrease the effects of those threats by using appropriate elements of design.

I would like to clarify that by saying 'environmental harms' I do not mean that such harms are caused *by* the hospital environment. In fact, all of the harms mentioned so far (i.e. potential harms, purpose–related harms, and environmental harms), can be caused by the hospital environment. For example, falling on the floor is a potential harm which can happen because of slippery floors. 'Environmental harms' in fact refers to those harms which are caused by

being in the environment of hospitals; by *being* in the environment of hospital, for example, a patient cannot be with his family in the normal way.

4.6.2. A Humane Environment

As with my explanation of the two previous ethical principles of hospital design, I am now going to show how the principle of design for reverence can guide designers to identify their ethical responsibilities, by giving some examples. As the first example, the principle of design for reverence can guide designers to think about the needs of people to communicate and be with their families. In her seventh central capability of human beings (i.e. the capability of affiliation), Nussbaum emphasises the importance of "being able to live with and toward others, [and] to recognize and show concern for other human beings" (Nussbaum 2006: 77).

Accordingly, being with others and having the chance to properly communicate with relatives and family, is one of the central capabilities which people are entitled to enjoy. To deprive them unnecessarily of this entitlement is to fail to respect their dignity adequately. However, the environmental limitations of a hospital inevitably deprive people, particularly patients, of such entitlements. To act against this harm, the principle of design for reverence suggests designers try to make up for these kinds of harm to patients. This is because the elements of design of a hospital *can* support social communication for patients (Melin, Götestam 1981). A badly designed hospital, in contrast, can have a negative effect on social support. Open–plan rooms, for instance, are shown by a study to deter proper communication between patients and their relatives (Sällström, Sandman et al. 1987).

The environmental condition in hospitals can also reduce the level of some other human capabilities, such as the capability of senses, imagination, and thought. According to the Nussbaum's definition of this capability, people are entitled to freely exercise their religion (Nussbaum 2006: 76). However, patients inevitably will lose the ability to enjoy this capability in hospitals, if those hospitals are not suitably prepared for such entitlement. Design for reverence, however, requires designers to revere this right and provide for the religious interests of people in hospitals. Offering a suitable prayer room wherein people can pursue their own religious practices is an elementary example which should be considered. However, focusing more deeply on the nature of religious ceremonies and rituals reveals other subtleties in engaging with religious interests in hospitals. This demonstrates the need to know more about different rituals and practices in various religions so that designers can provide an appropriate environment for the exercise of religion.

Religious considerations in hospital design would be more complex when the different users of a hospital follow various different religions. However, in some cases hospital designers can still allow for different religious expectations. Catherine Robinson, for instance, describes how a hospital was designed in a way which was suitable for the different religious beliefs of members of the Indian Army of the Raj; namely, Sikh, Hindu and Muslim. In this project, hospital designers could not only provide for worship, but also they could deal with other interests and cultural requirements associated with these religions such as providing for funeral rituals, the culture of castes[106], religious diets and so forth (Robinson 1996).

There are many other human requirements in hospitals which are highlighted by the principle of design for reverence, some which are emphasised in the pre-existing literature and documents, such as respect for privacy, segregation, and even the cleanliness of the hospital environment. In general, the principle of design for reverence asks designers to think about the environmental harms that the hospital can impose on people.

To summarise, in the previous chapter I tried to address the entitlements of people in hospitals by bringing the Capabilities Approach into the context of the hospital environment. In this chapter, I endeavoured to consider the implications of this theory in a narrower discussion – namely by identifying ethical principles of hospital design addressed to the designers. I concentrated on the notion of the 'threshold' in this theory: a level of capabilities which everybody is entitled to practice and in the absence of which life would not be compatible with the dignity of human beings. I defined the condition of being beneath this threshold as 'harm' and, in accordance with the Capabilities Approach, I stated that the ethical responsibility of hospital designers is to provide a hospital environment that can facilitate the removal or alleviation of such harms. I defined this task as a two-step mission: stop worsening and start enhancing.

In this regard, I introduced three ethical principles: to stop worsening the condition of people in hospitals, I suggested the principle of 'design for vulnerability' targeting the potential harms

[106] It is important to notice that the ethical principles of hospital design defined in this thesis, are based on an egalitarian sense of human dignity in which the status of all human beings have the same value. Therefore, moral hospital designers should ensure that the provisions they design for people do not ignore the equality of human beings. In this light, if providing for the culture of castes, as in this example is against such equality, the designer should morally refuse to plan for such provision, even if it is a part of a religion, culture, and so on. My aim in citing this case is only to show how the environment of hospitals can be flexible in providing for different requirements including religious and cultural interests. Of course, such provision, as I mentioned, should be in accordance with the implications of human dignity.

in hospitals. For the second step of the mission of designers – i.e. to start enhancing people's capabilities – I suggested two ethical principles. Firstly, the principle of 'design for healing' which aims to remove purpose-related harms. Secondly, the principle of 'design for reverence' which addresses the harms which are related to the restrictions imposed by being in the hospital environment.

I also strived to show that these ethical principles can handle the findings of certain studies. However, as was discussed earlier, ethical arguments in the field of the hospital environment are rare, and we do not yet have substantial discussions on the relevant ethical dilemmas so that I can examine the abilities of these principles. This is the reason why I tried to establish an intellectual structure for this field (ethical considerations in hospital design): to create a suitable platform for future discussions. This is also why my thesis concentrates on philosophical issues, rather than presenting a merely practical approach. However, having such a platform, I hope that more detailed and specific arguments will be discussed by scholars from different related disciplines.

Thus, my arguments are focused on the theoretical aspects of the hospital environment. As such, I need to elaborate certain aspects of these principles (as much as the limitations of this research allow me) so that it becomes clear how they should be utilised. In this regard, I think the following elaboration is instrumental to creating a better understanding concerning the function of the ethical principles of hospital design.

4.7. Elaboration of the Dignity Approach

4.7.1. Subjects and Instances of the Principles

Above, I tried to explain the rationale behind my suggested ethical principles. However, I need to address some further issues raised by my suggestions. The first issue concerns the subject of these principles. Following the idea of the Capabilities Approach, the suggested three ethical principles are based on the concept of human dignity. Respect for human dignity is a duty of all towards others. In terms of hospitals, the dignity of anybody who uses the hospital environment should be respected (or, in Nussbaum's approach, they are entitled to be supported in their capabilities); this means designers should note that the subject of these principles is not only limited to the patients and 'medical' staff. In this light, it should also be remembered that the staff of hospitals are not limited to those who have a direct role in the process of the medical treatment of patients (e.g. physicians, nurses, and the like). There are

also other employees in hospitals such as administrative staff, cleaners, maintenance teams, and so on, whose dignity should be respected as well. Accordingly, when a hospital designer wants to use the ethical principles to respect the dignity of the hospital staff, he has to provide a supportive environment for all of these groups, whether they are medical staff or not.

It is also essential to bear in mind that hospitals may have functions other than treatment[107]. Many hospitals, for example, provide a place for academic research, examination and education. Hence, the dignity of the people who use the hospital environment for these purposes is also important, and therefore a designer has to consider their entitlements too. This difference particularly applies in the case of purpose–related harms, because the purpose of these people is other than care. A designer who abides by the principle of design for healing, then, should expand this moral principle to all of these functions, and see if she can have an effect on purpose–related harms in these functions. Unfortunately, there is not yet a sufficient study of the impact of the hospital environment on those who use it for non–medical purposes. Therefore, further research is needed to identify the harms which people in hospitals may suffer who use its environment for purposes other than healthcare service, so that designers can find appropriate elements of design to combat such harms.

It is also vital to mention that the three ethical principles are not absolutely distinct in practice. The ethical principles suggested are based on a classification of the kinds of harms met in hospitals. I attempted to clearly distinguish those classes of harms from each other. However, in practice, instances of harms in hospitals can fall under more than one ethical principle. For example, if we consider insufficient sleep as a harm that can occur in the hospital environment, this can be dealt with by two ethical principles. On the one hand, a lack of adequate sleep can be caused by environmental harms in hospitals such as loud noises. In this regard, this harm should be prevented under the principle of design for reverence. On the other hand, however, this harm can be addressed by the principle of design for healing, if the reason for the lack of sufficient sleep is the pain a patient is in.

If a harm concerns more than one principle, it should not always be seen as a single problem. This is because several sources can cause such harm in hospitals and, consequently, designers need to tackle all of those sources. For instance, in the case of a lack of sufficient sleep, hospital designers need to eliminate the environmental sources of noise as well as try to facilitate the ways in which the effect of pain can be decreased. If a designer considers only one of those sources in his planning then the patient may be harmed by the other sources, which would result in the continuation of the harm. Therefore, even though the application of these

[107] See section 4.5.1.

principles can in practice be for a single case, hospital designers have to take the different sources of harm into consideration and act against all of them; this is what the three ethical principles invite hospital designers to do.

4.7.2. Conflicts Between Ethical Principles

One of the central issues related to ethical principles in the context of bioethics concerns the conflict between ethical principles. The same question may be asked about the ethical principles of hospital design. For example, if a designer can provide an ICU in a way in which nurses can see all of their patients from their station, this might be good in terms of the reduction of staff fatigue, and enhancing the quality of care. However, it might simultaneously compromise the privacy of patients and their visitors. Similarly, a porter may prefer to work in a ward with wide corridors, but such corridors may intimidate the patient. Therefore, the question concerns how a designer should deal with such conflicts in the requirements of hospital users. As these ethical principles of hospital design are defined on the basis of the Capabilities Approach, I will consider how these problems are addressed by Nussbaum.

After explaining Nussbaum's point of view, I will point out some issues related to the concept of ethical responsibilities in the context of the hospital environment. Firstly, I will try to clarify that the ethical considerations and principles suggested in this thesis should be seen in the 'context of design': the result of which could be different from other fields of study in some respects. I will explain that the ethical principles in hospital design have a 'directive' function, which means we have to expect principles to lead designers to discover the main ethical requirements, rather than specifically determining the ethical obligations. I will also elaborate on the point that in the context of design and art we are talking about the 'incorporation' of requirements, rather than deciding between them. Therefore, a part of the ethical duty of hospital designers is to resolve the conflicts of requirements, and to try to include all of the ethical requirements in the form of the hospital environment.

Before addressing the relevant arguments of Nussbaum's theory, it is worth remembering a (somewhat obvious) point. What might be suggested as the cases of conflict in ethical issues in hospital design are, in fact, the conflict between the basic entitlements of human beings in hospitals. For instance, in the above examples, the conflict in the case of the ICU is between the right to privacy and the harm of fatigue. Likewise, in the case of wide corridors it is between the patients' intimidation and the porter's fatigue. Hence, we need to see how designers ought to deal with conflicts between basic entitlements of human beings in hospitals. Now, let us consider Nussbaum's ideas in this respect.

There are some important points of Nussbaum's thoughts which should be considered in this regard. As was mentioned[108], all (central) human capabilities are the sources of human dignity. In this regard, every basic entitlement of human beings matters and should not be sacrificed for the sake of other entitlements; or, in Nussbaum's term, a 'trade-off' between capabilities should be rejected (Nussbaum 2006: 85). How then should we avoid making trade-offs in the conflicts between capabilities? Nussbaum's answer is that we need to look across the capabilities to ensure that the set of capabilities is coherent and can be delivered as a whole (Nussbaum 2006: 175-176).

This means that if we cannot support all of the basic capabilities of people thoroughly, then this signifies that the list of capabilities has not been designed correctly. Thus, Nussbaum's answer in these cases is to reset the basic entitlements in the right way, such that we have a list of capabilities all of whose items can be supported without the need to ignore some basic capabilities. If, despite resetting the list, we cannot provide for the minimum entitlements of human beings, then in such a society people are living in an undignified condition. Furthermore, as all human beings have equal value, if we sacrifice the entitlements of one for the sake of others then regardless of which side is sacrificed we will have an undignified condition for at least the victim of such sacrifice.

This is the case in the hospital environment: according to the Capabilities Approach, a moral designer has to provide a hospital in which people have a decent condition. If she cannot prepare such a facility, regardless of which party is the victim of such an indecent environment, she is failing in the aim of her ethical approach (e.g. whether the porter should experience a difficult condition of work, or a patient should be deprived of a peaceful environment, the result is that the environment of that hospital is not a decent one). Therefore, with regard to cases of conflict, the theoretical answer of this thesis is that we need to redesign the basic entitlements of human beings in hospitals in such a way as to ensure that designers can support all of those entitlements without conflict[109].

If any conflict remains then the situation is undignified and the designer has failed to meet her ethical responsibility[110]. This is the answer that can be given to questions concerning ethical conflict, without considering its meaning in the context of hospital design. However, looking

[108] See section 3.2.10.

[109] Also, see section 4.9.

[110] Compare this statement with Nussbaum's position: "In desperate circumstances, it may not be possible for a nation to secure [all capabilities …] up to the threshold level, but then it becomes a purely practical question what to do next, not a question of justice. The question of justice is already answered: justice has not been fully done here" (Nussbaum 2006: 175).

at the ethical responsibilities of hospital designers, it seems that the notion of conflict between ethical issues is unimportant for a moral designer: such a designer will incorporate all of the ethical concerns. I am going to unpack some more aspects of hospital design in order to explore what the conflict between entitlements could mean in the context of design. This can also help in better understanding the function of ethical principles in this context.

Beauchamp and his colleague (as well as many other bioethicists) base their discussions on bioethics on some main ethical principles, namely respect for autonomy, beneficence, non–maleficence, and justice. They describe the function of these principles in medical ethics as "an analytical framework intended to express general norms of the common morality that are a suitable starting point for biomedical ethics. These principles should function as general guidelines for the formulation of the more specific rules" (Beauchamp, Childress 2009: 12). Subsequently, they tried to address the ethical discussions about bioethical issues by considering their suggested ethical principles. For example, they address some ethical dilemmas such as informed consent, disclosure, voluntariness, and the like, under the issues related to the principle of autonomy.

The general theme of the ethical principles of hospital design is similar; that is, to set some ethical principles which "function as an analytical framework" and "guidelines", and they are a "suitable starting point" for the field of the ethical environment of hospitals. These similarities, alongside the fact that hospitals are one of the main mediums in which the bioethical dilemmas take place, can cause us to inaccurately view the ethical principles of hospital design in the same manner as bioethical principles. Despite the similarity of the subjects of these two fields of studies, it should be noted that they are related to two different spheres. The language, methods, and the context of designing and architecting is different from the context of medicine and bioethics. Therefore, the principles of hospital designs should be read with the language of design and art.

One of the main characteristics of the artist is their *creativity.* A designer, as an artist, should be able to flourish in her capability of creativity. To design means to consider a list of requirements and, accordingly, to create an environment in which all of those considerations are addressed. Designers use different elements and technologies to meet such a mission in their job. They should not be excessively restricted by determining the details of design. They should be allowed to think about the requirements and see which elements and what shape of hospital can address the required items. The more a designer is restricted, the more they lose their sense of creativity. In this regard, the ethical principles of hospital design should be able to *direct* designers to the main areas of requirements, instead of determining the features of design. Hence, ethical principles have to have a level of *generality*, but leave the details to the

designers so that they can fit the requirements to the hospital environment. This is what I have strived to do in this thesis.

As was mentioned earlier[111], the main ethical expectations from the hospital environment are expressed with the two concepts of people's dignity and their entitlements. However, as I argued, the notions of human dignity and rights are vague for designers and it is difficult for them to bring these concepts into the field of design. The difficulty is due to the fact that they are not usually trained for philosophical arguments. Therefore, it is necessary to interpret such notions using suitable concepts in the correct context and to clarify what designers should do in this respect. I have tried to elaborate a sense of human dignity and entitlements which is compatible with the context of hospital design (i.e. by using the Capabilities Approach). I have then endeavoured to bring those philosophical notions into the context of hospital design by interpreting them with more sensible conceptions for designers in the format of three ethical principles.

As a practitioner in this field, I believe that these three ethical principles are sufficiently directive and inspiring for designers and can guide them down the ethical road of their job. However, again, such guiding principles should have a level of generality and avoid determining every single issue in a way that causes, in designers' words, "a stifling effect on design" (Hignett, Lu 2009: 615). Therefore, instead of determining certain elements of design for every ethical case, we need some general ethical principles with a directive function which can guide designers to find the best elements of design on their own. For example, designers should not be commissioned to design a wide corridor to ease the work of a porter, which itself can cause a conflict with the interests of patients (i.e. by causing a feeling of intimidation for the patients). Rather, designers should be asked to provide an environment in which porters can work easily and patients can feel peaceful and relaxed. At this point, designers should be left to find a solution for these two requirements on their own.

Given the above explanation, if a designer simply plans a wide corridor which is suitable for the porter but is inappropriate for patients or, alternatively, designs a narrow corridor to satisfy the patients by undermining the rights of the porters, then she has failed to meet her ethical responsibility. She meets her ethical duties if, as Nussbaum points out, she sees the list of capabilities as a whole, and designs in such a way so as to ensure that both requirements are

[111] See section 2.1.

addressed. In general, the ethical principles of design should have a directive function which needs to be sufficiently general and sensible for designers[112].

There is another aspect in the nature of design which I think is essential to consider. As was stated, a hospital is a facility that is created by designers. Therefore, it is the designers who shape their subject (i.e. the hospital environment) in a way that they desire. The environment (i.e. the subject of design) is, thus, a changeable item. What a hospital designer does in her planning is, in fact, to consider a list of requirements (e.g. what is required by medical treatment, or hospital commissioners, aesthetic issues) and limitations (e.g. technical limitations, budget, available space), and then attempt to create the hospital environment with suitable elements and technology in a way that can address those considerations. Hence, a designer has to try to *incorporate* such considerations into the space of hospitals. In contrast to the human body which has a relatively fixed nature, designers can shape their subject (i.e. the hospital) and use different materials and technologies to make it in the way that they want – i.e. in a way that can address the requirements. This means that if designers see an element of design that is contrary to the capabilities of a group of hospital users, they *can* change it by using an alternative element with no harm to others. Therefore, the main concern of a hospital

[112] Looking at the ethical codes of designers confirms the existence of this sense of generality and a directive approach in defining the ethical responsibilities of designers. See for example, 2012 Code of Ethics & Professional Conduct by American Institute of Architects (AIA 2012), The Architects Code: Standards of Professional Conduct and Practice by Architects Registration Board (ARB 2010), Code of Professional Conduct by Royal Institute of British Architects (RIBA 2005), and Code of Ethics for Engineers by National Society of Professional Engineers (NSPE 2007). In exploring these codes of conduct, we can see that the ethical concerns in the professional relationship between designers, their colleagues, and their customers are discussed far more than their ethical responsibilities towards the building users. This is the case even though it is expected that designers should primarily serve the public interests even if this conflicts with the interests of their clients (Marcuse 1976: 270).
Here it is suitable to mention one of the problem facing such codes of conduct provided by renowned institutions. As Sadri says: "Today's codes of professional ethics focus on personal responsibilities of professionals rather than cover all the mechanisms involved in the emergence of the profession, and ethical problems in these mechanisms" (Sadri 2012: 88). In this respect, as I investigated in the above four samples of codes of conduct, I realised that notions such as providing for human dignity and rights, for instance, are not considered or reflected on in these references, except in a few cases. This signifies the importance of ethical principles for hospital designers: they do not currently have any substantial professional material by which they can discover their ethical responsibilities toward people in hospitals.

designer is to incorporate *all* of the requirements of people in her design by choosing the suitable elements and technologies which cause no conflict between entitlements.

The aforementioned Indian hospital is a practical example of this claim. As was mentioned[113], the hospital users were from different religious backgrounds. Their religious requirements in some cases were apparently in opposition to others (e.g. their diets). However, the designers of that hospital could fully incorporate these religious concerns within the space of the hospital. Therefore, what is important in the design of a building is how successful its designers were at incorporating different requirements into the environment of that building (e.g. when we say a hospital is well-designed this means that the environment of the hospital is beautiful, suitably easy to use, sufficiently equipped for any needs of its users, etc.).

Overall, since designers 'create' their subject (e.g. hospitals) they have a chance to 'incorporate' the requirements and limitations in the form of a building. The ethical failure of a hospital designer, hence, does not occur when she 'decides' wrongly between two ethical requirements; rather, the failure happens when she fails to 'incorporate' the ethical requirements into her design. In other words, a designer has ethically failed in her job if she sacrifices the entitlements of some hospital users in order to respond to some other entitlements. This is the reason for my insisting on the generality of ethical principles: if we over-specify the requirements of people in hospitals (e.g. specifically ask the designer to provide wide corridors to ease the job of porters), we limit the designer's ability to manoeuvre the elements of the design to address the entitlements of others.

My concern in this thesis, then, is to figure out how ethical requirements should be *added* to the other requirements in hospital design (e.g. medical requirements, technical restrictions, etc.). I am aware that non-medical requirements have, to a certain extent, already been considered in the design of hospitals, particularly since the satisfaction of patients became a key concern in healthcare services[114]. However, the problem that I have found is that such ethical considerations are arbitrarily chosen and there is no systematic structure with which designers can ensure that they are considering *all* of their ethical requirements in their process. The ethical principles of hospital design, in this light, are defined in order to highlight the main areas that designers should consider in order to discover the key ethical requirements in hospital design. After identifying these ethical requirements, they then need to design their hospital in a way that addresses all of those requirements. I believe that 'art' is powerful and

[113] See section 4.6.2.

[114] See section 4.8.2.3. for a discussion concerning the Evidence-Based Design approach in hospital buildings.

instead of leaving designers in situations of 'deciding' between requirements, through innovative ideas and technologies it empowers them to incorporate all of the requirements together into the hospital environment. In general, as hospital designers are the creators of the hospital environment, instead of thinking about which requirements should be sacrificed for the sake of others, they need to concentrate on alternative ways, methods, elements of design, or new technologies in order to find out how they can incorporate apparently conflicting ethical requirements.

What can appear to us as a conflict of ethical entitlements in the context of hospital design can be divided into three kinds. I am going to mention a practical example for each kind of conflict to show that ethical conflicts can be removed by deliberation in the design of the hospital. The first kind is pertinent to those instances in which the entitlements of one person may appear to conflict with the entitlements of other people. The example of the Indian hospital illustrates that a carefully designed hospital *can* address the different (and even in some cases opposing) interests of hospital users. The second sort of conflict is the kind in which providing for some of one's own entitlements demands a condition which harms one's other entitlements.

For instance, the beds of patients in emergency departments are usually separated by curtains (instead of solid walls), so that physicians can get access to patients quickly in emergency cases. However, such separations cannot provide sufficient privacy for patients, particularly when they are talking with their doctors. In this case, the capability of life and bodily health of a patient seems to conflict with their right to privacy. How can a designer deal with this conflict? This can be done in many ways. The Modular Bed Pod, invented by Nightingale Associates / Bilings Jackson Design, can be suggested as a suitable solution to this problem. While this Bed Pod benefits from using curtains as separators (which is appropriate for the emergency departments), it has an acoustic system by which the volume of the conversations between patients and doctors can be reduced to avoid being overheard. This is an example which shows that the conflicts between one's entitlements can be removed by means of the hospital environment.

The aforementioned Modular Bed Pod is a part of broader project which is called *design for patient dignity.* This project was launched in 2009 by the "Design Council, [...] Department of Health, and healthcare specialists from the Royal College of Art Helen Hamlyn Centre to develop new designs showing how different privacy and dignity issues could be solved" (Design Council n.d.). They suggested some innovative elements of design that can address the entitlements of patients, particularly concerning patients' privacy and segregation. One of their ideas is related to segregation: a requirement when being hospitalised in a same-sex ward. This project aims to solve the problem of wards that have already been designed with a mixed-

sex situation in mind. The problem is that there is not enough money or space to change the current wards. This is the third kind of conflict that I can imagine occurring, where an entitlement of a person (or group of people) is in conflict with resources (e.g. lack of budget, space, etc.). To resolve this problem, they simply designed Retractable Screens with a light material that can be easily installed and uninstalled by which they can segregate the ward, or provide private space around a bed. These are a few examples to show how designers can be flexible in solving the conflicts between ethical requirements in hospitals.

Although designers are planning for hospitals which are places for medical activities, the processes of design and construction are from other disciplines – e.g. design, engineering, architecture. Therefore, the suggested ethical principles for hospital design should be considered within such a perspective (which might be different from other disciplines). In this regard, I explained that the ethical principles for designers should have a level of generality, which should offer an interpretation of moral concepts such as dignity and rights in a way that is sensible for designers. Such principles then empower designers to discover the ethical requirements of hospitals.

At this point their ethical responsibilities, according to the Capabilities Approach, are to provide a hospital environment in such a way as to ensure that people can enjoy their basic entitlements. I also hold that the art of design is sufficiently flexible so as to allow designers to avoid making trade-off between entitlements; whether it is a conflict between some entitlements of a person with her other entitlements, the entitlements of a person with the entitlements of others, or the entitlements of a person with the resources. The ethical responsibility of the hospital designer is to include all of the ethical requirements of people, rather than deciding between them. Thus, if a designer sacrifices the entitlements of one for the sake of others, she has failed to meet her ethical duty.

4.8. Evidence–Based Design (EBD)

In the previous chapter, I suggested a list of capabilities which I think is compatible with the requirements of people in hospitals. This list is specified partly according to the findings of scientists, in which the impact of the environmental elements of hospitals on patients and others are investigated. It suggests the main entitlements of people in hospitals. The next step in this thesis was to propose three ethical principles for hospital designers by which they can identify the ways in which those entitlements might be threatened, and accordingly focus on the elements which can remove harm to people in hospitals. I think that with this package (i.e. the compatible list of central entitlements of people in hospitals, alongside the ethical

principles of hospital design) we have established an analytical structure by which designers can ensure that they are addressing the ethical requirements of hospital users.

As this approach is based on the theory of the Capabilities Approach, which itself is based on the concept of human dignity, I suggest naming this ethical method of hospital design the *dignity approach.* The central concern in the dignity approach is to encourage the design of hospitals environments that respect the dignity of people and provide support for a decent experience of life during their stay in hospitals. Now it is time to see how the dignity approach can improve the current method of hospital design. As was mentioned earlier, the ethical requirements of people have already been considered in the process of design. In this regard, I am going to explain Evidence-Based Design as a method in which the effects of the hospital environment are considered in the process of design. Then, I will show that this approach has some ethical risks (or gaps) which cannot guarantee an ethical environment in the context of the hospital environment. Subsequently, I will argue that my suggested dignity approach with its intellectual structure offers a way that avoids the ethical risks in EBD and thereby enhances the current method in hospital design. For this purpose, I need to briefly introduce and analyse EBD.

As a subset of, or parallel to, the patient–centred approach in medical care, there is an approach to hospital design which is called Evidence–Based Design (EBD) (Becker 2009: 25, Ulrich, Zimring et al. 2004: 26). Its aim is to create hospitals based on research which considers the effect of the physical environment on people. The more precise definition of evidence–based design could be:

> Evidence–based design is a process for the conscientious, explicit, and judicious use of current best evidence from research and practice in making critical decisions, together with an informed client, about the decision of each individual and unique project (Hamilton, Watkins 2009: 9).

Indeed, there is a growing body of studies in this field which shows a deep link between the environment of hospitals and patients, staff, and organisational outcomes (Harris 2008: 3). Generally, this approach is capable of improving the quality of patients' experience and health outcome in hospitals, while it can bring the benefit of saving both cost and time (Phiri 2014: 3). A research team from Texas A&M University and Georgia Tech could identify more than 600 rigorous studies among several thousand research projects in 2004 (Ulrich, Zimring et al. 2004: 2 – 3). This study was updated and expanded four years later with reviews of more new research in this field (Ulrich, Zimring et al. 2008). Such a considerable number of research projects indicates a deep relationship between hospital design, on one hand, and outcome and cost, on the other hand (Ulrich, Zimring et al. 2004: 26).

Whereas a few decades ago we knew a little about the relation between physical environment and physical or mental condition of people in hospitals (Sommer, Dewar 1963: 339)[115], these and similar studies show that well–designed hospitals that improve privacy, reduce noises, with better ventilation and many other factors, can positively impact patients, families and staff. Considering such elements in the design of hospitals suggested by EBD can improve effectiveness, reduce stress, increase patient safety, and bring many other improvements in the condition of people in hospitals (Ulrich, Zimring et al. 2004).

Thus, EBD addresses many ethical and clinical impacts of the hospital environment. In this regard, if EBD is comprehensively successful in covering all ethical demands of people, there will be no reason for a further, separate dignity–based approach in hospital design. In contrast, if EBD falls short of all moral demands of people in hospitals, then it will signify that a more inclusive approach is needed. Such an inclusive approach should be able to deal with the ethical concerns in hospitals as well as the interests of EBD. In this light, an overview of the issues which EBD has mainly emphasised would be beneficial for at least two reasons.

First, considering the areas of focus in EBD could help us to know more about this approach; and consequently, this makes it easier to analyse the ethical aspects of EBD. In this way, we can find out if EBD is properly able to cover all ethical needs of people. Moreover, exploring the EBD can assist us in having a useful perspective of the capabilities of the hospital environment. If we want the design of hospitals to respect the dignity of people, it is important to make ourselves familiar with the abilities of hospital design in respecting people. For this purpose, I am going to outline some aspects of the main effects of hospital environment mentioned by EBD.

4.8.1. Some EBD Concerns

4.8.1.1. Privacy and Confidentiality

Privacy is one of the primary concerns of patients in all hospitals[116], particularly where it is not available (Sadler, Berry et al. 2011: 13). Nowadays, privacy has become an assumed

[115] Complaining in 1963 about the lack of studies about the effect of the hospital environment on people, Sommer and Dewar said "More is known about the spatial needs of animals in zoo and circuses than about spatial needs of people."

[116] See, for example, Leavey et al. (2006).

condition of the care process for people (Moore, Chaudhary 2013: 1), and in some cases it is considered as one of the measures for physical environment assessment (Glind, Roode et al. 2007: 155). Privacy in hospitals is classified in different forms. For example, Allen (1997: 33) has categorised four forms of privacy: physical privacy; informational privacy; decisional privacy; proprietary privacy. However, Lin et al. have considered it in three types that is 'privacy of the patient's body, space and condition' (Lin, Watson et al. 2013: 174). In spite of various possible classifications of privacy, there is no doubt that the physical environment and design of hospitals can protect (or endanger) the privacy of patients.

The challenges raised by patients' privacy can involve different aspects. For instance, in some countries, such as Nepal, medical consultations can be taken in one room with several doctors while medical students are probably there and able to listen to the conversations (Moore, Chaudhary 2013: 1). Even in one department, conditions of privacy may be different. For example, in one case study, it is shown that the privacy in those spaces in a hospital emergency department which are situated nearer to staff work places can be endangered (Mlinek, Pierce 1997). The arrangement of bays in NHS hospital wards, can threaten the privacy of patients in many ways such as allowing the overhearing of conversations between medical teams and patients, lack of sufficient personal information privacy, and the like (Woogara 2005). Sometimes a lack of privacy in the physical environment would impose extra difficulties for nurses. For example, in a study in Taiwan in which the physical environment is not properly configured for patient privacy, nurses try to use a low voice in their conversations with patients in order to keep patients' information confidential (Lin, Watson et al. 2013: 174).

Many studies have also shown that privacy and confidentiality of patients are frequently ignored in emergency departments (ED) (Mlinek, Pierce 1997). In EDs patients' privacy is at stake for different reasons involving physical design. EDs mostly have rooms which are separated by curtains which may cause a perceived lack of space privacy (Lin, Lee et al. 2013: 6). However, review of EDs' design can lead to protection of patients from overhearing and being seen by others. This redesigning could involve providing inner or private space and also rooms with solid walls for examinations (Lin, Lee et al. 2013: 5 – 7).

Respect for patient's privacy is also important for confidentiality in hospitals. The insistence on confidentiality in medicine is rooted in ancient times. The Hippocratic Oath is an example: "Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret" (Hippocrates 400 B.C.). Although sensitivity about medical information may vary for different ages and genders, many patients would forgo telling their

medical problems to health carers if they are unsure about confidentiality (Moore, Chaudhary 2013: 2 & 3).

All in all, privacy and confidentiality are important ethical needs of patients in hospitals. Such moral requirements demand an earnest endeavour to recognise the effective elements of the design in protecting privacy in hospitals. To solve the problem of privacy, many suggestions can be rendered. Having single–bed rooms is one of the most common and is recommended for the majority of the departments in the hospitals. It has many obvious advantages in terms of respecting patients' privacy (Persson, Anderberg et al. 2015, Berry 2013, Ulrich, Zimring et al. 2004: 26 – 7). The privacy enabled by single–bed rooms is also preferred by nurses, in a case study, in regard of the suitability for examination of patients by healthcare personnel along with some other advantages (Chaudhury, Mahmood et al. 2006). Suitable use of acoustic materials can also be considered as another means to protect privacy (Ulrich, Zimring et al. 2008: 136), although it has some other benefits such as lessening the adverse physiological effects of noise (Hagerman, Rasmanis et al. 2005) as well as creating a quieter environment in hospital (Philbin, Gray 2002).

The above examples along with many other studies caused EBD to consider privacy and confidentiality as one of the main ethical concerns. Considering these studies, which illustrate the effect of environmental privacy on the condition of people in hospitals, the EBD approach recommends that designers seek effective methods to protect the privacy of patients. Respect for privacy and confidentiality, on the other hand, are ethical rights of people in hospitals. Therefore, a moral designer shares this concern with the EBD approach. In this respect, then, the EBD approach and dignity approach are in the same boat.

4.8.1.2. Stress and Anxiety

"To be happy is to be unstressed"; however, people experience different types of stress in each hospital (Buckle 2015: 210). The stress and anxiety in hospitals does not only belong to the patients and visitors; the medical team and staff are dealing with high levels of stress as well. The hospital environment can be highly stressful for medical teams and particularly for nurses (Gowell, Boverie 1992). This problem becomes acute when the stress of nurses adversely affects a number of factors such as the quality of care and absenteeism (Alsaraireh, Quinn Griffin et al. 2014). Therefore, all people are at risk of stress in the hospital environment. The physical environment itself can exacerbate the stress of people in hospitals. For example, the noise in the hospital is a source of stress (Ulrich, Zimring et al. 2004: 5).

However, research demonstrates that the design of hospitals is a factor in patients' stress reduction (Ulrich 2000: 1 & 8). There are a number of ways in which hospital design can lead to reduction of the level of stress. Providing views of nature and positive distractions; creating hospital gardens; making the environment pleasant–feeling, comfortable, aesthetically pleasing and informative (Ulrich, Zimring et al. 2004: 21, 22, 25, 26 & 27) ; supportive design for staff, such as providing adjustable workstations and comfortable break areas (Ulrich, Zimring et al. 2004: 26 – 7, Ulrich 2000: 1 & 6);designing in respect for privacy, socially supportive areas (Ulrich 2000: 5) and clear wayfinding (Cahnman 2014) are some of the examples of the positive effect of the environment on people by well–designed hospitals. Therefore, design for reduction in stress and anxiety is the one of the central concerns in the EBD.

4.8.1.3. Social Support and Communication

The need for social support and appropriate communication with staff tends to be the single most crucial factor for overall satisfaction with care in all categories (Ulrich, Zimring et al. 2004: 24). For instance, social support by close relatives of terminally ill patients can increase the sense of life fulfilment and overall life satisfaction of dying patients (Dobríková, Pčolková et al. 2015). Even outside the hospitals, social support has a significant role in the prescribed treatment regimen of a patient (Pinto, Schub 2016). Social support is also an essential contributor to the well–being of patients with some particular illness, such as diabetes(Aylaz, Karadağ et al. 2015), HIV patients (Lifson, Workneh et al. 2015), depressed cancer patients (Oh, Ell 2015), and discharged patients from intensive care units (ICU) (Tilburgs, Nijkamp et al. 2015).

Even though hospital design itself cannot create a communication, it can play a crucial role as a part of an 'organization's ecological system' (Becker 2009: 26). In other words, hospital design can facilitate or pave the way to good communication in hospitals. Such a supportive hospital environment results in better recovery outcomes, in addition to satisfaction of both staff and patients (Becker 2009: 26, Ulrich, Zimring et al. 2004: 23 & 24, Ulrich 2000: 5 & 6). Although a few years ago there was little research regarding the role of hospital design in communication (Kelly 2003: 2286), EBD suggest some suitable elements in hospital design to provide a socialised environment, such as well–designed waiting areas, proper access to food, telephone and restrooms, appropriate accommodation for the night, and social and relaxing environments, like gardens with sufficient sitting and meeting areas for patients and their relatives (Ulrich 2000: 6). Moreover, providing single–bed rooms can give a suitable opportunity to family and friends to have appropriate communication with their loved–ones

(Ulrich, Zimring et al. 2004: 23, 26 & 27). Although, single–bed rooms may act negatively for socialising the young inpatients, if it does not suitably provide accommodation for parents (Morgan 2010).

4.8.1.4. Quality of Care and Outcomes

Quality of care and better outcomes are significant targets for EBD advocates. A large body of research illustrates how well–designed hospitals can positively influence the quality of care. Better quality of care is not always seen as a counterpart of other ethical concerns (e.g. privacy, stress, etc.), but it is considered as a concern under the heading of which all these items are gathered. For instance, a research team identified some areas of outcomes on which physical environment can impact, which involve reduction of staff stress and fatigue; increase in effectiveness of care delivering, improvement of patient safety, reduction of patient stress levels; improvement of clinical outcomes; and finally improvement of overall healthcare quality (Ulrich, Zimring et al. 2004: 3). Even lack of natural light from windows can be harmful to patients in critical care (Ulrich 2000: 3). Bright light, in contrast, can have an effect on 'depression', 'sleep', 'length of stay' and many other parameters (Ulrich, Zimring et al. 2004: 20).

Given the above explanations, some considerations such as good communication, which can reduce the anxiety of patients and families, would result in positive outcomes and patient satisfaction (Ulrich, Zimring et al. 2004: 24). Another example is the single–bed room, which was reported above to be one of the highly recommended methods for providing an appropriate setting for proper communication between the patient and staff or her family. Moreover, in addition to the effect of well–enabled communication on the quality of care, single–bed rooms are also able to "lower hospital–induced nosocomial infections, reduce room transfers and associated medical errors, greatly lessen noise, improve patient confidentiality and privacy" and can thereby "increase patients' overall satisfaction with health care" (Ulrich, Zimring et al. 2004: 26), all of which can be considered as an increase in the quality of care.

As it can be seen many parameters are studied which can have different effects on the quality of care such as reduced stress and anxiety for patients and family (visitors); improved sleep; reduced pain; lower infection occurrence; improved patient satisfaction; benefits for staff (reduced stress, improved job satisfaction, possibility of reduced turnover, greater attraction of qualified employees); cost savings by improving medical outcomes (such as reduced infection occurrence; reduced intake of costly strong analgesics; and some patients might be

moved sooner from intensive or acute care to less costly care units) (Ulrich 2000: 8, Glind, Roode et al. 2007: 155).

4.8.2. Ethical Failures of the EBD Approach

Thousands of research projects have investigated the effects of the physical environment in hospitals on people. A wide range of issues have recognised the impact of the hospital's environment. What are mentioned above (e.g. stress and anxiety, social support, quality of care and better outcome), are some major items which have frequently been considered in these studies. Having a substantial body of research in these fields, EBD pays considerable attention to the capabilities of design in order to serve people in healthcare buildings. The brief explanation above was an attempt to show some aspects of the power of the art of design to address various needs of people in hospitals. Relying on such vital documents which illustrate the scope of capabilities of design to respect the dignity of people, EBD appears to be a consistent method of design to address the interests of patients. Now the question is whether or not such a patient–centred approach can successfully respond to the *ethical* needs of patients (and other users of the hospital environment).

At first glance, it seems the answer is affirmative because there is much research in which morally relevant aspects of hospital design are investigated. However, the studies which are the basis of EBD are questionable with regard to the ethical entitlements of patients. There is no doubt that providing for privacy, reducing of stress, and the like concern the entitlements of people in hospitals. However, we ought to know on what basis these entitlements are chosen to be considered in hospitals. It seems the answer for EBD is: these are scientific findings. EBD uses scientific findings to seek the relation between the physical environment and people. But the following ought to be clear: on the basis of what idea are these entitlements grounded?

Although different research projects may use different concepts to convey the object of their research, the core concerns of EBD can be generally classified under the following headings: *medical outcomes* (i.e. how the hospital environment can affect the process of care and improve the health condition of people in hospitals such as by decreasing medical error, pain of patients and so on), *financial issues* (i.e. how the hospital environment can minimise the cost of treatment), and *satisfaction* (the effect of the environment on the satisfaction of people in hospitals). In the following, however, I will show that this is not a suitable basis for designers to pursue their ethical duties.

4.8.2.1. Medical Outcomes

A considerable portion of the body of research in this field investigates the relation between the physical environment and clinical outcomes. For example, in a 2008 literature review Ulrich et al. define two criteria to separate the credible evidence from the rest. One of them is the quality of the research and the second is the ability of the research to show "the influence of environmental characteristics on patient, family and staff outcome". Subsequently, they divide outcomes into three general types: patient safety issues (e.g. infection, medical errors and falls); other patient outcomes (e.g. pain, sleep and stress); and staff outcomes (e.g. injury, stress, work effectiveness and satisfaction) (Ulrich, Zimring et al. 2008: 102 – 3). Setting such criteria for their literature review signifies that the majority of the evidence which is credible for the EBD approach, in the view of this research team, is that which supports any improvement in medical outcomes.

Briefly, EBD has a vested interest in those studies which portray any changes in hospital design which affects the clinical outcomes of patients. Consequently, the reason that advocates of EBD may be attracted to a plan for the reduction of stress, for instance, is its clinical effects, such as the improvement of the immune system of patients (Malkin 2008: xii) or the blood pressure and heart activity (Ulrich, Zimring et al. 2004: 21). Even when opponents of EBD talk about the ethical environment of hospitals, it can be seen that their statements have a medical flavour:

> Institutions should give top priority to patient–centred health care, and build an ethical environment to improve quality of care (Lin, Lee et al. 2013: 7).

Obviously, it is hard to say that it is impossible to find any evidence of concern for the needs of patients, irrespective of medical outcomes. It is beyond the scope of this thesis to examine all evidence involved in the EBD approach. However, what I am saying is that the overwhelming focus of EBD is centred on medical outcomes and financial issues. Therefore, EBD's evidence usually refers to these two parameters. My claim is not that such studies are not reliable. My point is that the ethical requirements of people in hospitals are not limited to these issues, and they include a wider range of entitlements, and therefore, as I am going to explain, relying only on these findings may distract designers from the other important entitlements. Before I explain the reason for this claim, I have to admit that this strategy of EBD to rely on research into medical outcomes is understandable for two reasons. The first is the fact that the chief concern in the hospital is the care process. Accordingly, it is natural to see the same interest as the core of the EBD approach. Moreover, medical outcomes are more measurable than ethical outcomes. Therefore, it is to be expected that evidence regarding the ethical needs of patients in EBD will be a reflection of evidence regarding medical outcomes.

However, such a focus on medical outcomes implies that if researchers cannot find any relationship between responding to the ethical requirements of patients and clinical improvements for patients, it cannot be expected that EBD considers these ethical requirements. Whereas, hospital designers have a responsibility to facilitate for the ethical requirements of patients – even if there were no research to show it has any positive effect on the healing of patients. In fact, the problem with the EBD approach (or, in other words, designing based only on the fields it studies) is its relation to clinical evidence when the ethical needs of patients can be beyond the scope of health outcomes.

For example, Ulrich and his colleagues (Ulrich, Zimring et al. 2008), who use health outcome criteria to validate research for EBD, failed to address the importance of a number of capabilities which I have suggested as the central entitlements of people in hospitals. If designers focus on the medical outcome and its necessities, what would be the status of the requirements of the capabilities of play, practical reason, sense, imagination, and thought? How would the environment support patients to enjoy their right to laugh, to play, to be able to live with animals and plants, or to follow their cultural, personal, or religious interests? There is nothing substantial about the importance of facilitating for such entitlements in hospitals among the recommendations Ulrich and his colleagues make on the basis of their literature review. This might be because they were unable to find any rigorous work which assesses, for example, the effect of religious practice on the health condition of patients. However, the point is that even if no research could find any relationship between these entitlements and medical outcomes, it is still the right of people to have an opportunity to pursue all their basic entitlements; and designers have an ethical responsibility to facilitate them in hospitals. The same problem (or worse) can be seen in the other chief concern of EBD – its consideration of financial benefits.

4.8.2.2. Financial Concerns

Similar to the concerns about the medical outcomes, it is important for EBD to know how the design of hospitals can reduce the cost of healthcare services. Sadler et al. for example, believe "[c]hanges in the physical facility provide real opportunities for improving patient and worker safety and quality while reducing operating costs" (2011: 13). This concern is because besides the price escalation of building a hospital, the cost of medical procedures themselves is a principal concern (Malkin 2008: xiii). Therefore, another main part of the evidence considered in the EBD approach is those kinds of studies which can specify any reduction in the cost of the care process.

Moreover, it is also crucial for hospital designers to know if the patient–centred approach in EBD would impose extra cost for healthcare budgets. To respond to such concerns, some research states changes in hospital design in order to improve medical outcomes, such as reduced infection occurrence, reduced intake of costly strong analgesics, and the movement of some patients sooner from intensive or acute care to less expensive care units, can help to save the cost of care in hospital (Ulrich 2000: 8). For EBD "most supportive characteristics or strategies probably cost no more than poorly designed or unsupportive facilities and many cost less" (Ulrich 2000: 8).

It is justifiable for designers to see how they can reduce the price of healthcare. However, similarly to the design for outcomes, ethical issues covered by EBD under the guise of financial concerns cannot guarantee support for patient's moral requirements. The ethical needs of people in hospitals are essential because patients are human beings. The dignity of patients should be respected even if that respect does not increase either the quality of care or help to save costs. I mentioned above that in some studies, authors try to prove that design for better medical outcomes does not impose a considerable extra cost to the hospital providers. However, I believe that the ethical rights of people in hospitals should be responded to even if it needs an extra budget. For the same reason that many states provide standards of the rights of people in their nations and dedicate considerable funds to support human rights (e.g. education), the minimum rights of patients regarding the hospital environment should be specified. All hospital providers and designers, then, should be obliged to provide for such minimum rights of people even if there is a cost for hospital providers.

Therefore, EBD cannot claim that it completely considers the ethical needs of patients. This is because the entitlements they focus on in their planning are not coming from a systematic structure which can guarantee that all ethical requirements are addressed. This approach, rather, is based on scientific findings. In other words, EBD considers those entitlements for which there are considerable studies affirming its positive effect. But, it would be probably silent for the other entitlements. In contrast, my suggested dignity approach starts from the basic entitlements of people in hospitals. I first determined a list of the central entitlements of human beings in hospitals[117]. Identifying the key human entitlements, I introduced three ethical principles to show how those entitlements might be harmed in hospitals. With such a

[117] See section 3.5.

systematic structure, hospital designers would know how they have to plan, as they would know to what entitlements their hospital should be responsive[118].

However, EBD proponents may still believe that this strategy of hospital design is sufficient for the moral demands of patients. This is because of EBD's concerns about the satisfaction of hospital users. Researchers have explored the satisfaction of patients during their stay in hospitals, as well as the satisfaction of family and staff. Obviously, without a proper answer to the ethical needs of people in hospital, they would not be satisfied, at least not fully satisfied. Therefore, it might be thought, by considering the satisfaction of patients, family and staff in hospital design, the ethical needs of patients would be answered automatically. It does not matter if evidence used by EBD considers the ethical needs of patients; since the satisfaction of patients is an important element, EBD can cover the ethical needs of patients under that heading. This answer needs more scrutiny.

4.8.2.3. Patient Satisfaction

Nowadays, it is expected that the environment of hospitals can improve many previously unexpected factors such as medical quality, reduction in the evitable costs, minimizing the length of stay, patients' satisfaction (or 'feel–good') and so on (von Eiff 2012: 48). This implies that hospital environments can play a considerable role in improving the satisfaction of people in hospital. Enhancing the patients' and staff's satisfaction would result in better outcomes (Ulrich 2000: 8) and can make the job easier (Ulrich, Zimring et al. 2004: 5). Satisfaction of patients can be gained in different ways, such as the feeling of being satisfied with the quality of care provided. For example, it is reported that creating gardens and nature in hospitals would result in patient and family satisfaction with the quality of care given there (Leavey, Papageorgiou et al. 2006: 89). In other research the provision of single bedrooms is suggested as a way of improving of satisfaction with health care (Ulrich, Zimring et al. 2004: 26 – 7).

In one case study, researchers tried to redesign the environment and medical processes in an emergency department with the aim of improvement of patient satisfaction and privacy. Their

[118] As was mentioned, the two principles of 'design for vulnerability' and 'design for healing' are mostly about medical outcomes. However, it seems EBD has missed the harms one may experience in hospitals for merely being in the hospital environment (i.e. those which are addressed by the principle of 'design for reverence'). Although this concern, as I am about to explain it, might be, to a certain extent, removed by EBD's insistence on 'patient satisfaction'. However, as I will explain, the notion of satisfaction cannot guarantee all of the ethical entitlements of people in hospitals.

study shows their attempts were successful and that redesigning the physical environment (such as providing private observation areas for patients) improved the satisfaction of patients (Lin, Lee et al. 2013: 7). They also show that patients who stay in the hallway for their treatment were more dissatisfied in comparison with those who were treated in wards (Lin, Lee et al. 2013: 7). Designing for various conditions can impact satisfaction in hospitals. Good communication and more comfortable, aesthetically pleasing, and informative environments can be counted as instances of such conditions. Leavey et al. believe safety, privacy and dignity are important factors to determine patient's satisfaction in wards (2006: 89)[119]. All in all, studies have confirmed that the environment of hospital can undoubtedly improve the satisfaction of people.

In previous passages, I mentioned that research regarded by the EBD is predominantly concerned about the effect of the physical environment on either quality of care or cost. Whether the concerns about satisfaction are rooted in the improvement of the quality of care or reduction of the cost, people would not be satisfied if their moral needs were not responded to appropriately. This might seem to tell against the dignity approach in hospital design, because satisfying patients would already involve respecting their dignity. Thus it might be argued that the satisfaction approach in the EBD is sufficiently inclusive of ethical demands and there is no need for a separate dignity approach. Therefore, two notions in the context of hospital designing can be considered both of which might be thought to enable designers to fully appreciate people's rights: dignity and satisfaction. Now we should see which one of these two notions can respond to the ethical needs of patients most thoroughly and appropriately.

To answer this question, firstly it should be mentioned that it is not true that every attempt to satisfy people would be necessarily a moral action. People may be satisfied by many things which are not necessarily ethical. For instance, some people may like to eavesdrop over the conversations between physicians and their neighbouring patients, but hospital designers should not provide for such immoral interests of these people just to satisfy them[120]. Therefore, over–emphasising the importance of patients' satisfaction could misguide the designers in this regard. The significance of satisfaction of people in the hospital design should be defined in an ethical framework. Hence, it might or should be supposed that the satisfaction mentioned

[119] Dignity in this sense seems to be a subset of or a means to satisfy patients. In the next few passages I will challenge this claim.

[120] Compare this point with the Nussbaum's believe about 'bad' capabilities which should be prohibited, explained in section 3.1.3.4.

by the EBD is the 'moral satisfaction' which is not correspondent with unethical demands of patients.

However, I still believe that moral satisfaction cannot be a reliable alternative to the dignity approach. Even after limiting satisfactions to morally permissible satisfaction, it is still possible to imagine many practical situations in which acting according to ethical duty would not necessarily be accompanied by experienced satisfaction. A terminal patient in a coma who cannot consciously understand what is going on around her and does not have any relative who can accompany her during his stay in hospital, can be an example of this case. She is alone and finally will die soon, but still there are many ethical duties toward her which should be fulfilled. For instance, she has the right that her medical information be kept confidential and that she be protected from public viewing. A due and appropriate response towards her ethical rights is a duty for others, even if he cannot understand and consequently be satisfied with these ethical arrangements[121]. Nobody can ignore her ethical rights just because those ethical affairs cannot *satisfy* the patient. Thus, satisfaction of people in hospital is not a comprehensive criterion for assessing the ethical environment in hospitals.

In addition, the satisfaction approach even can be misleading for designers. The reasons for taking the satisfaction of people in hospitals to be important can be different, but, the financial concern undoubtedly is a primary one. Rivalries between healthcare providers compel them to convert their healthcare system from a professional–centred attitude to the patient (or costumer)–centred approach. Such a change in the method of healthcare service highlights the importance of the patients' satisfaction (Vuori 1991). In the 'hospital industry', as Raju et al. say, many healthcare providers are taking concrete strategies to apply principles of marketing. In such an industry, in their point of view, hospitals should be effective in four areas: gathering and using information; improving customer satisfaction and reducing complaints; researching and responding to customer needs; and responding to competitors' actions. They also emphasise that 'customers' of hospitals include not only patients but also physicians, insurance companies and other groups (Raju, Lonial et al. 1995). In such competitive healthcare marketing tools to monitor the satisfaction of patients are in great demand (Ware, Hays 1988).

Thus one of the main contexts within which the satisfaction of patients is defined is the financial concerns of hospital administrators. This concern even caused the establishment of Press Ganey in 1985, and after that many other companies, to give survey and advice service about the satisfaction of patients to healthcare organisations (Siegrist Jr. 2013). Thus,

[121] Consider the responses to Macklin, who believes that respect for dignity is the same of respect for autonomy, explained in section 2.4.1.1.

satisfaction of patients in hospital does not necessarily have ethical concerns. In a financially–oriented consideration of satisfaction, the interests of people matter to the extent that meeting them obtains a better financial performance. This means that providing for the moral needs of persons which does not reflect anything in terms of the cost saving, may lose its priority. Even, in this point of view, the priorities may change. See the statement below:

> Recent consumer research has shown that those born after the baby boomers are much more computer savvy and self–research their potential healthcare providers, relying more heavily on the patient experience reported by others. Millennials (those born after 1982) are far less likely to choose their care site by physician recommendation and are more likely to respond to branding and amenities provided. So far, healthcare organizations have predominantly focused on appealing to older generations who are by far the largest consumers of health services, especially in acute care settings. But as younger generations begin to take on caregiver roles for parents and grandparents, they'll likely demand more service, communication, and a satisfying physical environment (Cahnman 2014: 2).

Considering the above statement, if the satisfaction of customers is the aim (as it is in a financially–oriented satisfaction point of view), designing for satisfaction would suggest hospital providers designing for young caregivers rather than old patients, which is far from the main aim of building a hospital as a place to cure patients. It may cause hospital designers to sacrifice the ethical needs of the patients (who are in the more vulnerable situation) to obtain the satisfaction of younger caregivers. For instance, this approach may suggest dedicating funds to provide a Wi–Fi and computer services for the young caregivers rather than providing a supportive social area for the old patients (providing that the funds are enough only for one of these two amenities). In general, design for satisfaction not only cannot completely respond to the ethical needs of people in hospitals, but also it can cause, in some cases, the ethical needs of people to lose out to the financial concerns of healthcare providers. Therefore, designers should be cautious in the context of satisfaction as used in the EBD. They should figure out the meaning of satisfaction used in a given piece of evidence and make sure it is not contrary to the ethical rights of patients.

4.9. The Dignity Approach

In this chapter, I suggested three principles – design for vulnerability, design for healing, and design for reverence – as the ethical principles of hospital design. These principles, alongside the compatible list of entitlements within the context of hospital design suggested in the

previous chapter, constitute a method in hospital design which I call the Dignity Approach. I also analysed the current approach in hospital design – i.e. EBD – in which designers use empirical scientific findings pertinent to the effect of the hospital environment on people in their design of hospitals. Although in this approach the ethical requirements of patients are considered, I attempted to show that this approach cannot guarantee an ethical environment in hospitals. It is now appropriate to explain the advantage of the dignity approach over EBD. In fact, I need to explain how the dignity approach can fill the ethical gaps in EBD. In this regard, let us review the definition of EBD mentioned above:

> Evidence–based design is a process for the conscientious, explicit, and judicious use of current best evidence from research and practice in making critical decisions, together with an informed client, about the decision of each individual and unique project (Hamilton, Watkins 2009: 9).

In the process of design, a designer should make decisions concerning environmental elements which can address the requirements of the hospital commissioner. As each project is 'individual and unique', the designer and her commissioner should consider the characteristics of their own project and discover in which ways they can deal with such requirements. In this framework, EBD suggests designers use 'current best evidence from research and practice' in the process of design. Citing some references, for instance, a designer may suggest a plan of design to a commissioner in which the rooms will be brighter and thereby cause a less stressful atmosphere in that hospital. In the same way, a designer may be able to find some other evidence showing how the hospital environment can impact on the condition of people in the hospital. For example, the designer may consider some literature reviews in which a list of rigorous studies in this field are listed, such as the Ulrich et al. piece I previously discussed. In this way, she may set a list of human requirements which can be addressed by a well-designed hospital. What kind of evidence is this? Looking at the literature reviews in this field, it is clear that the evidence is usually empirical scientific findings in which a causal relation between an element of design and a group of people in a hospital environment are investigated.

EBD is praiseworthy in running an approach in which the ethical requirements of people are weighted. Patients' privacy, their satisfaction, segregation, communications, and the like are important entitlements which are dealt with by EBD. My concern, however, is with the inclusiveness of this approach. As I argued in the previous section, designers cannot ensure that a designer can address *all* of the central entitlements of people in hospitals if they rely only on the EBD method. This is because, there is a considerable risk that one or more aspects of human entitlements are missing from the research. Thus, even though the entitlements that EBD deals with are admirable, they are not suitable as a starting point.

Although we cannot ignore the empirical findings we need a systematic basis which highlights the basic entitlements of people in hospitals independently, so that we can seek the best empirical findings which can address those pre-defined entitlements. The advantage of this strategy is that designers know what facilities they should provide, even if there is no scientific evidence connecting such facilities with patient satisfaction or medical outcomes. For example, a hospital designer may dedicate a space for a buffet in the hospital so that a family can eat properly while they are visiting - even if there is no evidence which shows such amenities can improve medical outcomes, financial benefits, or the satisfaction of patients. Overall, EBD has an ethical gap due to its failure to address all of the relevant moral concerns in hospital design.

Such an ethical gap cannot be removed by including 'ethical arguments' as part of the 'evidence' of EBD. This is because EBD's *problem of uncertainty* in covering all of the main ethical entitlements will remain: we would need the same systematic basis upon which designers can follow the relevant ethical arguments. In addition to this problem, using 'ethical arguments' in the process of design might be difficult in practice for designers. We should remember that the evidence cited by designers in EBD is usually easy to understand for them. They are expressing which characteristic of the hospital environment is good for what (e.g. bright rooms are good for lessening patients' stress). It is possible that this sensible and practical content is what has attracted designers to consider this evidence in their planning. However, the ethical arguments are not that easy to grasp for designers who are not usually trained for such arguments. Furthermore, there are not many ethical arguments in the context of hospital design and environment - whereas there are considerable scientific findings. For instance, EBD says single bedrooms are good for privacy, which can transparently direct designers in their project, but the ethical arguments do not usually address a specific element or character of design[122].

As I mentioned earlier, many different ways might be suggested to deal with this issue. This is because this field is almost untouched and there is no substantial argument on these issues. However, my idea is that the problem of uncertainty can be removed if we establish a clear

[122] I might be criticised for an inconsistency in my argument: whilst, here, I am objecting to the generality of ethical arguments, I previously (in defining the ethical principles) insisted that the ethical principles of hospital design should have a level of generality. It should be noted that what I mentioned as generality in ethical principles was about the importance of flexibility for designers in selecting the elements of design. Here, however, I think the ethical arguments should not be general for designers in a way that they cannot be linked to the practical issues of design.

understanding about human dignity and rights, and then try to find a systematic basis for ethical requirements in hospitals. Again, scholars may suggest different theories in this light, but my suggestion is Nussbaum's Capabilities Approach. According to her theory, the concept of dignity can be explained in terms of having a decent life, which is compatible with what we are looking for in hospitals for people. It was also explained that human beings are worthy of respect for their (central) capabilities. Such capabilities, in contrast to Kantian dignity, emphasise human vulnerability and indicate that people are dependent on the external world and need to be supported. Having this theoretical framework, I suggested the dignity approach which has two complementary aspects, both of which are based on the ideas of the Capabilities Approach; a hospital design method which not only considers the empirical scientific findings and ethical arguments, but also removes the problem of uncertainty found in EBD.

Firstly, I defined a list of basic entitlements according to Nussbaum's list of capabilities. This list, however, was tailored for the ethical concerns in hospital design. This is an important difference between the dignity approach and the EBD approach. EBD looks at the research in order to discover what is suitable for patients, a strategy which cannot ensure that all of the main ethical requirements of people in hospitals are addressed, because it depends which requirements of patients have been studied. The dignity approach, first of all, defines a list of entitlements of people in hospitals according to an ethical theory (i.e. the Capabilities Approach). This can cause designers to consider all of the entitlements of people; even those which are not studied yet, or for which the designers could not find any rigorous and relevant studies. Furthermore, the dignity approach sees hospitals as facilities; the means with which to facilitate the respecting of the dignity of hospital users - which should be well-equipped and designed in order to fulfil this function. Therefore, even though a designer may not find evidence which can prove a direct impact of the hospital environment on people, having the list of entitlements she can think about the ways in which the hospital environment can facilitate supporting the entitlements of patients by hospital staff.

Such a list of basic entitlements opens a wider window than that provided by EBD – aiding designers to support people's capabilities in hospitals. Moreover, as the basis of the list of entitlements is defined somewhere outside EBD's references, it can remove the uncertainty problem in hospital design. In general, whilst EBD waits for researchers to introduce new aspects of the hospital environment that can impact on people, the dignity approach has a list of entitlements in hand. The dignity approach is not limited to taking advantage of empirical findings[123], but also considers the ways in which it can facilitate all of the entitlements of

[123] I will explain how the dignity approach uses scientific findings in its process in the next few paragraphs.

people by the means of the hospital environment. These issues are related to the first part of the dignity approach. After defining the basic entitlements of human beings, it is time to determine how a designer can support the entitlements of people by the means of the hospital environment.

This second aspect of the dignity approach was completed by suggesting the three ethical principles. As the foundation of the dignity approach is the Capabilities Approach, I used the conceptions of this theory in this second stage; particularly the idea of the 'threshold' as the minimum level of basic entitlements which everybody should be able to enjoy in order to have a 'decent life' – i.e. a life worthy of human dignity. I called the condition of being beneath these thresholds 'harm'. The three ethical principles of hospital design –design for vulnerability, design for healing, and design for reverence – show the main three pathways in which people might be deprived of their minimum entitlements; the pathways can be blocked (or discouraged) by the elements and characteristics of design. In fact, in the dignity approach, I have separated what was already mixed in EBD. EBD determines what element of design is appropriate for what good (or what entitlement). The dignity approach, however, separates the two: it first defines the good in hospitals (i.e. people's entitlements), and then detects what element of design can address those entitlements.

What is the status of scientific findings in the dignity approach? Scientific findings can play roles in both aspects of the dignity approach. I was inspired by the empirical findings in designing the list of entitlements compatible with the requirements of people in hospitals, as I explained in the previous chapter. In the same way, it can be used for updating the list of entitlements. As Nussbaum stated, the list of capabilities is open-ended and is subject to change. We need to review the list of people's entitlements in hospitals constantly, to ensure it is up to date. Research and practice may be utilised in such updating. If empirical findings signify any important aspect of human entitlements in hospitals which is missing from the list, it should be welcomed and added to the list[124]. However, this opportunity does not exist only for empirical findings.

Ethicists can help more significantly than scientists in enhancing the list of entitlements. More than empirical findings, ethical arguments can underscore the aspects of human life and entitlements which need to be supported; aspects which are not currently mentioned in the list

[124] It seems, in this stage of the dignity approach, it is the list of entitlements which can help scholars in their research, rather than vice versa. Having the list of basic entitlements, scientists can now recognise the main requirements of people in hospitals that need to be addressed. This can help them to identify the topics that they should focus on; namely, the capabilities of human beings which we know less about (with regards to how they can be affected by the environment of hospitals).

of capabilities. Overall, if a scholar from any discipline (including ethics and science) suggests any entitlement which is not addressed in the list of capabilities, it should be considered in the review of the list. To compare it with EBD, an EBD designer uses the latest findings in her research; but the dignity approach updates the list of entitlements of people in hospitals and renders such a list to designers to be used.

Therefore, enhancing the list of the entitlements of people in hospitals is a collective responsibility for all. This notion highlights one of the main ideas of Nussbaum with respect to the implications of her notion of dignity: the role of 'institutions' in collective responsibilities. I agree with this idea of hers: in certain cases, we need institutions to undertake and lead collective responsibilities. In this case I believe that, instead of designers, it is the responsibility of the pertinent institution (e.g. healthcare organisations such as the NHS) to provide and define such a list of entitlements. In this regard, they need to gather scholars from the relevant fields of study and reflect their points of view in such a list of entitlements, by considering the latest scientific findings, ethical arguments, practical experiences, and even people's complaints about the environment of hospitals. They also need to constantly monitor the latest debates and findings when upgrading the list. Such a list of entitlements could be considered a legal regulation, which would not only oblige designers to consider it in their job, but also discourage hospital commissioners from forcing designers to ignore ethical considerations in their planning.

The main function of empirical findings, however, emerged in the second part of the dignity approach, where the three ethical principles identified the ways people may be harmed by the hospital environment. Such findings can show the impact of elements and characteristics of design on people. For example, when a designer considers the fifth capability in the modified list (i.e. emotions) which insists that people have an entitlement to be relieved from stress, she might be interested in the evidence which indicates that unpleasant odours and air pollution can be sources of stress in children hospitals[125]. In fact, using the "current best evidence of research and practice" makes much sense in this stage of the dignity approach. This implies that a designer should be aware of the effect of elements and characteristics of design on people, and decide to select the best one by which she can remove the ethical harms. As far as a designer is well-informed about the studied effect of hospital elements on people, the latest relevant technologies, new ideas in hospital designing, and newly produced environmental materials, she can be successful in designing a hospital with minimised harm.

[125] See section 4.4.2.

This explanation indicates that the major ethical responsibility in the second stage of hospital design is on designers (and not on institutions). It is a hospital designer who should decide between the elements, materials, and forms of design in a way that can remove environmental ethical harms, and this means she is the one responsible for any failure in addressing peoples' entitlements related to the context of design. This is the reason that I believe that the ethical principles of hospital design should be general, so that the designer can be flexible in selecting the most appropriate material or form of design for the detected harm.

However, in this part of the dignity approach, institutions can help designers by properly educating and also constantly keeping them informed of the latest advances and news in this field. All things considered, the dignity approach does not ignore the positive aspects of EBD. The dignity approach, in fact, is an evolved version of EBD in which the ethical failure of EBD is removed in a systematic way; a way in which the empirical findings have the same role in enhancing the quality of design, but the ethical arguments can also assist in improving the sense of a 'decent life' in hospitals; a systematic approach in which an attempt is made to remove uncertainties by providing a list of entitlements which can show the main concerns in hospitals.

The dignity approach is at the beginning stage of its life. As I mentioned earlier, I have not seen a considerable theory (or group of arguments) which addresses the ethical responsibilities of hospital designers. Because of the limitations of this thesis, my focus was mostly on the theoretical basis of the dignity approach. However, many aspects of this approach still remain undiscussed, particularly the practical ones. I hope the suggestions of this thesis can pave the way for more arguments and debates about the ethical responsibilities of hospital designers, the result of which would be ethically suitable hospital environments: places where the rights and dignity of vulnerable people are sufficiently protected.

Chapter 5

5. Conclusion

5.1. Summary

In this final chapter I will summarise the overall argument of this thesis and then discuss the possible directions for future research that it suggests. I will finish by briefly explaining some of the particular considerations that I have provided in this thesis. The main concern of this research has been to find the ethical duty of hospital designers towards patients' rights. When one talks about the rights of patients, attention is usually centred on the duties of the medical team. However, from this perspective, responding to the rights of patients would be limited to the ability of the medical team; 'ought implies can'. This means that medical teams can respond to patients' rights only to the extent that they are sufficiently empowered to do so. A suitably designed hospital environment can play a key role in this regard. This is due to the fact that the design of hospitals is not only essential for enabling the process of care, but can also provide opportunities to hospital staff to deal with a wider range of patients' rights, without which many of the patients' rights would not be met. Consequently, medical teams are not the only group who have a responsibility to provide for the rights of patients in hospitals. No less than the practitioners in hospitals, designers, who create the environment, have their own duty towards patients' rights.

Therefore, we need an ethical approach which can show designers the requirements of people in hospitals, as well as the ways in which they can provide an environment that can sufficiently facilitate the supporting of those entitlements. In this regard, I suggested the Capabilities Approach as the leading theory, whose ideas concerning human dignity and entitlements can guide us in finding an appropriate method of design. As the concept of human dignity is the basis of Nussbaum's Capabilities Approach, I tried to develop her thoughts on human dignity and entitlements. In this regard, I discussed the arguments about human dignity in the light of a consideration of Kantian dignity, as a very influential account of dignity in the modern era. I structured the discussion of human dignity around three main areas – namely the meaning, the implications and the theory of dignity.

I explained that, for Kant, the concept of dignity meant human value and worthiness, and that this sense has some characteristics such as being inalienable, incomparable, unconditional, and inherent. It seems that this meaning of human dignity is dominant in the philosophical perception of the meaning of human dignity. However, as I explained, the concept of dignity has some other meanings in common language. I mentioned the suggestion of Schroeder who

defines three non-Kantian meanings of dignity – namely aristocratic dignity, comportment dignity, and meritorious dignity. Although Killmister tried to unify the four senses of human dignity, in section 2.5.1., I criticised her suggestions. Nonetheless, I suggested that we consider the non-Kantian meanings of human dignity as one single conception in which dignity reflects the condition of a 'decent life'. I labelled this dignity as 'decency'. In section 2.5.7., I attempted to show that Nussbaum has utilised both meanings of dignity (i.e. dignity as value and decency) in her works, even though she does not explicitly express such a difference in the meanings of dignity.

The fact that the concept of dignity has meanings other than that of 'value' was instrumental in replying to some of the objections against basing an ethical approach on human dignity. In section 2.4.1., I addressed three main objections against human dignity, particularly in the context of bioethics. One of these objections concerned a duality in the meaning of dignity: in some references in bioethics dignity has an inviolable sense (similar to the Kantian sense), and in some others dignity seems to be violable. The fact that the concept of human dignity does not have a single inalienable meaning can be considered a reply to this objection. The other objection concerned the vagueness of the concept of human dignity. While I admitted this fact, I explained that by considering dignity through the Capabilities Approach we can find a more concrete sense that can be linked to human entitlements. In this way, the problem of vagueness will not be serious in the context of hospital design.

The last important objection against dignity was related to the Kantian theory of human dignity. Kant believed that human beings are valuable for their capacity of autonomy of will. Macklin, accordingly, states that the concept of respect for dignity in bioethical documents means nothing other than respect for autonomy. In section 2.4.1.1., I tried to reply to this objection. Despite the general objection to Macklin's equating dignity and autonomy, it seems that Kant's theory of dignity is one of the most controversial aspect of his ethical thought. This is due to the fact that in his theory people with severe mental illnesses are excluded from the list of dignity-bearers. Despite the attempt of some scholars to modify the rationality-only criterion of Kant, it seems that the ideas of others, such as Nussbaum, are more acceptable due to their focus on multiple capabilities as the sources of human dignity.

It was explained that in Nussbaum's Aristotelian-Marxian conception of dignity, human beings are valuable in virtue of all of their central capabilities. In this light, she attempted to define the main capabilities of human beings, and argued that as people have moral standing in virtue of those central capabilities they are entitled to be supported so that they can develop, practice, or secure those capabilities. Therefore, provisions for those main capabilities can be considered the main entitlements of human beings. Human entitlements are one of the

implications of human dignity discussed in the section on Kantian dignity. Dignity also has other implications, such as human responsibilities, human equality, and respect for dignity. For their dignity, in Kant's view, everybody has certain entitlements. However, entitlements imply certain responsibilities: in Nussbaum's framework, they imply an obligation to support those capabilities. Therefore, hospital designers have ethical responsibilities to create hospital environments that are sufficiently supportive of the capabilities of hospital users.

Thus, the list of capabilities provided by Nussbaum can be utilised to determine what people need in hospitals. In this regard, I modified Nussbaum's list for the context of the hospital environment. For this purpose, I used the findings of two sources: the practical experience which can be mostly found in the documents of healthcare organisations (e.g. the NHS) and the scientific findings in which the impact of the hospital environment on patients are investigated. Considering these sources, in section 3.5., I suggested a specified list of people's entitlements in hospitals (i.e. a list of capabilities which determines the entitlements of people for being supported). This was the first part of a two-faceted design method addressing people's entitlements in hospitals. The next part, most pertinent to designers, identified the ethical principles for hospital design.

In chapter four I explained that the ethical missions of hospital designers are: firstly, to prevent the condition of people from worsening; and secondly, to enhance their impaired capabilities. The ethical principles to be applied in hospital design are a further specification of these ethical missions. In this respect, in the same chapter (i.e. chapter four) I suggested and discussed three ethical principles as the basis of hospital design which are interpretations of respecting human dignity in this context. For guidance in the first mission (i.e. stop worsening), I proposed the ethical principle of design for vulnerability. The fact that people in hospital are in danger from potential harms illustrates that people are extremely vulnerable in hospitals and designers have a duty to think about the ways in which their work can help protect people from being in even worse situations (e.g. through infection, medical errors, etc.).

Alongside that, hospital designers have a responsibility to consider the ways in which their work can improve the situation of people so that they can meet the thresholds of their capabilities. This is their mission of enhancing the situation of people in hospitals. I presented two ethical principles in response to this mission; namely, that of design for healing and design for reverence. The focus of the principle of design for healing is on those harms which are directly related to the purposes that people have for going to hospital (e.g. for patients it is to be cured, for physicians it is to treat patients, and so on). The principle of design for healing asks designers to contribute to the process of care delivery as well as consider how their design can help others in recovering from their purpose–related harms.

The principle of design for reverence concerns the need to protect and improve the capabilities that tend to be impaired or harmed by the environmental restrictions of hospitals. Being in the environment of a hospital, it is to be expected that people will undergo many hardships and restrictions. Attempting to remove (or at least mitigate) the harms which are not directly related to the function of hospitals (i.e. not directly the result of the delivery of healthcare service), is one of the results of considering people in hospitals as human beings. To respect such valuable beings, hospital designers should also provide for the non–medical needs of people. This is the main theme of the principle of design for reverence which aims to enhance the situation of people to a higher level (at least to the entitlement thresholds of the relevant capabilities). Taken together these three ethical principles, which are based on the concept of human dignity, can depict how designers can identify and meet their ethical duties towards people in hospitals. These three ethical principles of hospital design constitute the second part of the dignity approach.

In my view, the dignity approach can direct designers to identify the ethical responsibilities of their role. I mentioned in the first chapter that in my personal experience I explained the concept of human dignity to my architect colleague in order to draw her attention to an ethical failure of design. I believe that if I were to suggest these three ethical principles to her, instead of human dignity, she could more clearly understand what she needs to do. Particularly, if I also provided her with the list of basic entitlements in hospitals. To support this belief, I tried to show the strengths of the dignity approach by considering the ethical failure of the current method in hospital design. As we have seen, many studies have shown that the hospital environment can considerably affect patients, staff, and visitors. Based on such studies, the Evidence–Based Design (EBD) approach is defined as an approach in which designers attempt to use the elements of design which can positively affect the quality of care in hospitals; an approach in which patients are at the centre of their considerations.

In chapter four I argued that despite the positive move in responding to the needs of patients in this approach, it cannot be considered a holistic approach that captures and makes plain all of the ethical duties of hospital designers. What EBD does is to adopt the style and elements of design which research has shown to have a helpful impact on the healthcare delivered to patients. However, the emphasis on the quality of care and cost–saving in this approach, makes it more likely that many of the wider ethical needs of patients will be downplayed, overlooked or ignored. Furthermore, even though the satisfaction of patients in hospitals is an important concern of EBD, there is no guarantee that planning for patients' satisfaction about their surrounding environment ensures that all of the ethical duties of designers will be met.

Perhaps the failure of the EBD in properly providing for the patients' rights arises from the lack of a systematic method for placing the relevant research in a clear and comprehensive ethical context. The scattered research referred to by EBD needs to be laid on an analytical basis that can lead hospital designers to a comprehensive ethical understanding; an approach that is concerned with all of the rights of people using hospitals, and that strives to facilitate the design of hospital environments responsive to such rights. Such an approach can correct the ethical failures of EBD and guide both designers and researchers to find the best ethical service that can be provided by the hospital environment. This structured ethical framework can also enhance the official hospital design documents that currently fail to properly address the ethical needs of people in hospitals. Therefore, I see the dignity approach as an evolved version of EBD, which not only improves upon EBD's ethical shortcomings, but also provides a systematic foundation upon which scientific findings can be considered in the context of hospital design.

All in all, the dignity approach suggested in this research can guide researchers and designers to respond to the rights of people in hospitals *comprehensively* by establishing an analytic framework for the ethical design of hospitals. The three ethical principles of hospital design, namely design for vulnerability, design for healing, and design for reverence, alongside the specified list of entitlements, illustrate the zones that a moral designer has to focus on when guided by the dignity approach.

5.2. The Need for Further Studies

In the previous chapters, I mentioned that this research should be considered a starting point in the field of the ethical design of hospitals. (Not a starting point in the sense that Beachamp and Childress defined their principles of biomedical ethics, as their principles were a starting point from which to argue and deal with the previously recognised ethical dilemmas in medicine; but rather a starting point from which to develop a new field of study in the context of hospital design). In this regard, in this thesis I have focussed my main considerations on the theoretical arguments; which means that many practical aspects of this topic remain to be explored. Thus, there is a need to work hard on the lesser-known aspects of this field of study. During the foregoing discussion, I have tried to mention other relevant aspects which can (and should) be studied in order to produce a strong body of evidence of the dignity approach in practice.

Here, I would like to briefly review them. As the dignity approach is double-faceted, I will divide the suggested areas of future study into these two parts. As was elaborated in chapter

three, the first part of the dignity approach is to determine the main ethical requirements of people in hospitals. I rendered an initial list of people's entitlements in hospitals by modifying Nussbaum's list and considering some practical experiences and empirical findings. This list of entitlements is general in the sense that it is designed in such a way so as to be applicable to all kinds of healthcare environments. Concerning the list, I can suggest two sorts of studies. Firstly, we need to work on the suggested list by considering a broader range of arguments and findings in different disciplines in order to (perhaps) improve the list of entitlements in this general form. Such investigations should be done constantly so as to ensure that the general list of entitlements is up to date.

The second sort of study is related to the ways in which this list should be read for each specific kind of hospital and medical service. In the same way that Nussbaum defines a general list of capabilities and suggests that her list can be modified for different societies according to their perceptions of the main capabilities of human beings, I think the general list of people's entitlements in hospitals can be modified for each kind of hospital. In this regard, there is a need to determine the meaning of each capability in any specific kind of hospital and medical service. For instance, what are the requirements of privacy in different parts of general hospitals, children hospitals, women's hospitals, and the like? This demands a two-step action: first, to determine a specific list of entitlements of people for all kinds of medical environments in hospitals; and second, to provide some explanations for each of these cases in order to depict clear expectations that a designer can understand. All of these aspects need to be studied in the future.

The second part of the dignity approach also demands further studies, which I categorise into two main groups. Firstly, the ways in which people might be harmed in hospitals should be made transparent for designers. The practical experience of staff, people's complaints about the hospital environment, psychological studies, and many other resources can help to provide a better understanding of the ways people are (or might be) harmed in hospitals. The other group of studies concerns new technologies, elements, materials, and forms of design which can help designers to remove the harms people may suffer in hospitals. Investigating all of these areas can enhance the dignity approach and thereby encourage designers to successfully incorporate such ethical considerations into their planning.

5.3. The Last Word

Before ending this thesis, I think it suitable to remind ourselves of certain considerations and limitations in this research. The first point is that the subject of this thesis is a matter for various

different disciplines such as philosophy, design and architecture, and medicine. Accordingly, to enhance this approach in the future, it is necessary that experts from all related branches discuss the implications of this approach in their field of study. Undoubtedly, considering the dignity approach from different points of view can help to improve this approach. Given that my aim was to establish an analytical basis for the dignity approach, inevitably the arguments of this thesis have a mainly philosophical flavour. Although I have tried to address the relevant documents and discussions from other disciplines where necessary, since this thesis concerns the intellectual foundations of the dignity approach, I have seen this subject mostly from a philosophical standpoint. Obviously, as mentioned above, the idea of this thesis can be developed from other perspectives as well.

The other point that we should remind ourselves of is related to the context of hospital design. As was mentioned above, the main theme of the arguments of this thesis is related to the philosophical sphere. I also endeavoured to form links between the discussions of this thesis and the fields of bioethics and medicine. However, it should not be forgotten that the arguments and principles of this thesis are provided in order to be considered by *designers*. Designers are from a branch of art, with their own perspectives and backgrounds. Therefore, all the arguments of this thesis should be seen from the viewpoint of a designer as an artist. For example, the ethical principles for hospital design are not intended to strictly determine certain formulations for all designers as if they are rigid protocols of action. Rather, they have a *directive* function to lead designers to consider important concerns in their planning, whilst allowing them a certain level of flexibility when considering different alternatives in their search for the optimum shape and function of an environment for its intended requirement. The other relevant conceptions in this thesis (e.g. the ethical responsibilities – or duties – of hospital designers) should be seen with the same framework in mind.

The final point, which I have already elucidated and will therefore not explain again here, is the fact that this thesis should not be taken as the final statement or conclusion of the dignity approach, but as the beginning of this method of hospital design. What I have attempted to do in this thesis is to illustrate the current lack of a comprehensive ethical approach in hospital design, and then to suggest an ethical approach (i.e. the dignity approach) that might remedy this lack. Therefore, further detailed research into hospital design in the light of this approach still remains to be discussed. This research is an attempt to show the need for, and define the basis of, the dignity approach and its associated ethical principles of hospital design, with the aim of providing guidance for the design of hospital environments that are fully in the service of the ethical needs of all of the relevant people.

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